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***The Making of Human Rights Politics:
Contentious Governance and the Uneven
Implementation of Human Rights***

*The Case of Irregular Migrants' Unequal Access to Healthcare in
Spain after Royal Decree Law 16/2012*

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Table of Contents

| | |
|---|----|
| Acronyms | 3 |
| Abstract..... | 4 |
| Introduction..... | 5 |
| Chapter 1: Theoretical Foundations underlying Irregular Migrants' Right to Health in relation to the Emergence of Human Right Polities..... | 7 |
| 1.1 <i>Human Rights and the Human Right to Health</i> | 7 |
| 1.2 <i>Irregular Migration and Citizenship</i> | 9 |
| 1.3 <i>Contentious Governance and the Making of Human Right Polities</i> | 12 |
| 1.4 <i>Conclusion</i> | 17 |
| Chapter 2: Research Methodology | 18 |
| 2.1 <i>Research Question</i> | 18 |
| 2.2 <i>Methods of Data Collection</i> | 18 |
| 2.3 <i>Methods of Analysis</i> | 20 |
| Chapter 3: Case Analysis of Irregular Migrants' Uneven Access to Healthcare After Royal Decree Law 16/2012..... | 24 |
| 3.1 <i>Context and Historical Background of RDL 16/2012</i> | 24 |
| 3.2 <i>The Institutional and Political Setting; Political Opportunity Structures</i> | 25 |
| 3.3 <i>Contentious Performances by Autonomous Communities</i> | 31 |
| 3.4 <i>Formation of Collective Actors</i> | 40 |
| Conclusion | 44 |
| Discussion..... | 46 |
| Acknowledgments..... | 48 |
| List of References | 49 |
| Annex 1. Overview of Analyzed Legislative & Administrative Documents..... | 54 |
| Annex 2: Overview of Political Party Positions | 58 |
| Annex 3: Information Sheet on Healthcare for Irregular Migrants in Cantabria..... | 59 |
| Annex 4. Interview Guide..... | 60 |

Acronyms

| | |
|--------|--|
| PP | Partido Popular |
| CSOs | Civil Society Organisations |
| ACs | Autonomous Communities |
| RDL | Real Decreto-Ley (Royal Decree-Law) |
| UN | United Nations |
| UDHR | Universal Declaration of Human Rights |
| CESCR | Committee on Economic, Social and Cultural Rights |
| ICESCR | International Covenant on Economic, Social and Cultural Rights |

Abstract

The emergence of 'new nationalism' is undermining the principle of universality and threatens the realization of human rights of irregular migrants. Within this context, and that of an economic crisis, Royal Decree-Law 16/2012 encroached upon irregular migrants' right to health in Spain. Despite its enactment at national level, several autonomous communities refused to implement the law, among other things in the name of the (human) right to health. The latter depicts the emergence of 'human rights polities'; local, regional or supranational political entities less subject to new nationalism that develop policies, contrary to the state's wishes, to protect human rights [and include irregular migrants]. This process constitutes a process of contentious governance, which can be analysed through the concepts political opportunity structures, the formation of collective actors, and contentious performances. In the context of RDL 16/2012, autonomous communities within Spain have contributed to bottom-up pressure to implement human rights standards at regional and national level. Among other things, the gap in the implementation of RDL 16/2012 can be attributed to different competencies and interests between the national state and the autonomous communities, political colour, diverse political opportunity structures and fragmented social pressure. The more inclusive nature of regional governments, I argue, is an argument in favour of the 'democratization of human rights instruments', especially given the recent upsurge of new nationalism.

Introduction

Like many other countries, Spain has been roaming in the dark pertaining to the ways in which to accommodate irregular migrants within its society whilst upholding human rights. Due to irregular migrants' migratory status and the restrictive nature of national legislation, irregular migrants are regularly in a vulnerable position and do not enjoy full access to economic, social and cultural rights (Garcés-Mascreñas and Chauvin, 2017). It is a well-known phenomenon that economic, social and cultural rights are frequently revoked during times of economic crises, despite the fact that they are subject to progressive realization. Within this context, following the economic crisis of 2008, the Spanish government enacted Royal Decree-Law 16/2012 to ban irregular migrants from primary health services, with the exception of minors and pregnant women (Ruiz, 2015). Interestingly, however, Royal Decree Law 16/2012 was not implemented evenly across the country. Despite the reality of restrictive national legislation, some lower levels of government designed health policies of a more inclusive nature, effectively granting irregular migrants access to healthcare services (Cimas et al., 2016). In so doing, autonomous communities played (and still play) a crucial role in providing access to health and ensuring the universality of the human right to health, which makes it an important unit of analyses - too frequently overlooked - in the governance of migration and the realization of human rights.

Although political landscapes differ across the regions, these cannot possibly explain the differentiated implementation solely. Cimas et al. (2016) found that: *'political party coincidence in the regional and national governments does not fully account for the differences in the implementation of the RDL 16/2012'* (p.386). At least 5 of the 17 autonomous communities that designed more inclusive health policies and thus turned their back on RDL 16/2012 had a PP ruling majority in government, so politically matching the national level (Cimas et al., 2016, p.386). Despite the corresponding political landscape, these regions implemented the Royal Decree-Law in different ways and, more interestingly, actively challenged it. In other words, other factors than solely political color must play a role; factors which may potentially be influenced by human rights advocates and defenders on the ground, as opposed to intangible political sentiments on higher levels that are difficult to steer. It is important to understand both the political and non-political factors that led to the implementation gap in order to grasp how the realization of the human right to health can be improved.

Why then did some regions act in accordance with the universality of the human right to health, whilst others followed the regressive national legislation? In other words, what factors influenced autonomous communities in providing access to health and how come some regions went further than others? Did autonomous communities disobey the national legislation out of a believe in the universality of human rights? Or did they do so for other reasons, such as public (health) safety, political mobilization from below, path dependency and so forth? In order to answer these and other questions, I aim to analyse what reasons and factors underlie the implementation gap of restrictive national legislation that excluded irregular migrants in Spain from the (primary) healthcare system. I will do so by means of a case study and hope it will lead to a better understanding of the challenges and the opportunities that exist with regard to the (regional and local) implementation and realization of the human right to health.

This brings me to the societal relevance of this thesis. Primarily, for any firm believer in the universality of human rights, it is vital to grasp how and why irregular migrants are excluded from health services in order to come up with strategies to include them. The latter is a necessity, not only to respect their human dignity and rights, but also since excluding irregular migrants from social services like health may contribute to further stigmatisation of migrants and overall racism toward this group (Soova & LeVoy, 2015, p.10). Moreover, since *'restricting access to social services for*

undocumented migrants can (...) undermine policy objectives in the areas of social cohesion, labour market, public health, and education strategies, and risk downgrading Europe's labour conditions' (Soova & LeVoy, 2015, p.10), understanding the factors that influence inclusion of irregular migrants on a regional level may ultimately contribute to a variety of positive social, economic and cultural impacts for society as a whole.

Academically, scholars have insufficiently paid attention to the critical comparison of regions within countries that unevenly implement human rights, for example in terms of the enactment of progressive versus restrictive policies in the area of health. So far, especially in relation to non-federal states, the academic emphasis has been on the local, city level on the one hand, and the national level on the other (Oomen, 2015; van den Berg, & Oomen, 2014), subsequently throwing the regional level on one heap with the local level or ignoring the regional level altogether, whereas they too have competencies relevant in the realization of human rights. It remains questionable why some regional levels of governments become defenders of human rights, while others do not. Instead of presuming the progressive nature of lower levels of government and/or ignoring regions that show regressive signs (Ambrosi, 2013), I aim to critically compare them. I expect there is much to learn with regard to the precise factors determining successful implementation of human rights at the regional vs. the national level in the context of irregular migration. Theories on contentious governance, politics, social movements, and path dependency will be analysed to shed light on the (non-political) factors that influence the successful implementation of the human right to health.

Now that the case has been roughly introduced and the societal and academic relevance has been elaborated upon, a theoretical approach will follow, which will form the framework of my research analysis. After the theoretical approach, the formulation of a research question will be outlined. Then, in the methodology, I will shed light on how the research question will be answered. Subsequently, a case analysis will follow in which I will incorporate, in a critical way, the theories discussed in the theoretical framework. After the case analysis, a conclusion and discussion will be provided, outlining the potential impact of my research for academia, as well as policy makers and human rights defenders on the ground.

Chapter 1: Theoretical Foundations underlying Irregular Migrants' Right to Health in relation to the Emergence of Human Right Polities

The theoretical framework will comprise of four parts. I will firstly elaborate upon my conceptualization of human rights and the human right to health, by positioning this work in the human rights field, using Dembour's (2010) four-school approach. Subsequently, the term 'irregular migrants' will be elaborated upon, among other things, in connection to theories on citizenship and (new) nationalism. Thereafter, I will relate all this to theories that may account for policy divergence among regions and the state, such as competing ideas of citizenship, path-dependency, and contentious governance, touching upon important concepts that will play a central element in the case analysis such as contentious performances, political opportunity structures, and the emergence of the human right polity.

1.1 Human Rights and the Human Right to Health

Both irregular migration and the human right to health - human rights in general, for that matter - can be interpreted in different ways. Depending on how one makes sense of human rights, among other things, one may evaluate different situations as constituting a violation of human rights. By positioning this work in a heuristic human rights model, based on the scholarly work of Dembour (2010), my understanding of human rights, and the human right to health in specific, will be elucidated upon; an obvious necessity before elaborating upon the relationship between irregular migrants and the human right to health. Moreover, by elaborating upon the heuristic human rights model, I aim to shed light on how we can account for peoples' (including judges') diverse evaluation of whether excluding irregular migrants from health services constitutes a breach in human right.

According to Dembour (2010), the human rights field can be subdivided into four schools of thought, each of them encompassing a specific understanding of human rights; the natural, the deliberative, the protest and the discourse school. Whereas each of the four different schools of thought differs in their understanding of human rights, they should be seen as *'overlapping orientations rather than clear-cut quarters'* (Dembour and Kelly, 2011, p.12). In other words, these different orientations may interact with one another so that it may well be possible for one scholar to belong to different schools of thought. Importantly, limitations of her model are recognized in her own work: *'The model is thus offered as a heuristic device which does not attempt to reflect the complexity of arguments made about human rights'* (Dembour and Kelly, 2011, p.12). Having said this, I will shortly elaborate upon the different schools of thought, before positioning this work and myself in the model.

Scholars belonging to the natural school will think of human rights as *'those rights one possesses simply by being a human being'* (Dembour, 2010, p.3). A central concept in this school is the concept of human dignity, which is a term reflected in many treaties and declarations. Not surprisingly, therefore, it is one of the most dominant schools of thought. Human rights, according to this school, derive their meaning from 'nature', which can be understood as something transcendental; for some this may be God, for other this may be reason, the universe, etcetera (Dembour, 2010, p.3). According to this school, the recognition of human rights by people and or states is not a prerequisite for the existence of them, although they do acknowledge that recognition in treaties and declarations is desirable. Lastly, scholars belonging to this school are generally optimistic about the potential of human rights law to prevent human rights violations from happening (Dembour and Kelly, 2011, p.18-19)

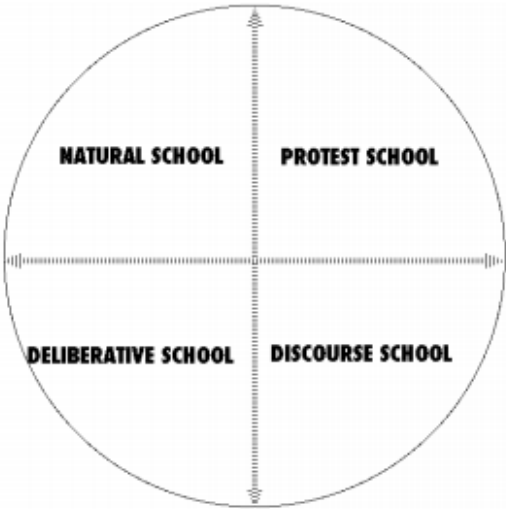
In contrast, scholars belonging to the deliberative school conceive of human rights as those rights that have been agreed upon between societies. In so doing, the deliberative school challenges the naturalistic view of the natural school and focuses on that which has been written down in law (Dembour and Kelly, 2011, p.19). Consequently, this school emphasises the limitations of human

rights; there is not more to it than that which has been agreed upon (Dembour, 2010, p. 3). In other words, human rights are created through a deliberative process, and they do not exist beyond that.

The protest school puts human rights central in the fight against oppression and the pursuit of social justice (Dembour, 2010, p. 3). Scholars belonging to this school conceive of human rights as claims that the oppressed can deploy in combatting injustice, although they acknowledge that there are more human rights in existence than just those that have been enshrined in laws. The latter derives from the believe that human rights law is ultimately in the hands of an elite, which may have contradicting interests compared to the oppressed (Dembour, 2010, p. 3). Scholars belonging to this school of thought are more concerned with the economic and political systems creating marginalization and human rights violations, and are therefore less optimistic about the potential of human rights law.

Finally, scholars belonging to the discourse school do not conceive of human rights in the natural sense, but in the discursive sense. That is to say, although they do not belief in the human rights idea, they do acknowledge that their existence in political discourses can make them powerful tools. Within this school of thought, given their lack of a belief in human rights, scholars often call for the need of an alternative movement of emancipation (Dembour, 2010, p. 3).

Figure 1. The Human Rights Field



Source: Dembour (2010, p.5)

I would position myself, and by extension this thesis, somewhere in between the natural school and the protest school. In other words, this work regards human dignity as central to human rights and finds affiliation with those scholars who argue that everyone is entitled by nature to certain basic rights, which ultimately derives from our common humanity. At the same time, however, this work acknowledges that protest and political struggle are essential elements in the realization of these rights, given skewed economic and political systems underlying human rights violations. Furthermore, in line with the protest school, it should be acknowledged that a slight suspicion to human rights law is paramount, as it is incomplete at best, among other things because the human rights regime is currently not well suited for the protection of those who lack legal recognition/lack citizenship. Moreover, this work finds agreement with the argument that there are more human rights than those that are protected by law, such as the right to global freedom of movement and/or the right to sexuality/sexual orientation.

Having been explicit about my position and by extension that of this thesis in the human rights field, it is critical to zoom into the human right to health to elaborate on what it exactly entails and encompasses. In a legal sense, the human right to health is a economic, social and cultural right and enshrined in various treaties such as the Universal Declaration of Human Rights (art. 25) and the International Covenant on Economic, Social and Cultural Rights (ICESCR) (art. 12) (Da Lomba, 2011). Because *'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'* falls under economic, social and cultural rights, national governments are subject to progressive realization using the maximum number of resources that are available to them (Da Lomba, 2011, p.360).

The right to health encompasses, among others things, access to health services, but can even be interpreted as including access to housing and sufficient and adequate food (Tobin, 2012). Given the scope of my thesis, I will leave open the question of whether the right to health also constitutes certain obligations of states to provide adequate food or access to housing. In this thesis, therefore, I will refer to the right to health in a narrow sense, with reference to the right for everyone to have access to healthcare services, including both primary and emergency care.

Relating the right to health to irregular migrants, it must be remarked that the need of healthcare among irregular migrants is frequently high, given that they constitute a particular vulnerable group. Firstly, the (traumatic) process of illegal immigration frequently has consequences for one's physical and mental health, and secondly, lacking forms of social protection, irregular migrants often live and work in bad conditions, which furthermore negatively impacts their health (Cimas et al., 2016). In practice, however, it can be observed, among other things since access to primary healthcare is not guaranteed in Europe, that irregular migrants make less use of primary healthcare than the average person or regular migrant (Winters, Rechel, de Jong, & Pavlova, 2018).

1.2 Irregular Migration and Citizenship

Although everyone is entitled to rights, in (legal) practice it can be observed that certain groups are frequently excluded from the enjoyment of human rights, among these are irregular migrants. To make sense of why this is the case, I will define the group 'irregular migrants', and link this to theories on citizenship and nationalism.

An important observation that can be derived from the literature is that a proper term to define the category of migrants who are living in a country, in which they do not enjoy legal authorization, does not exist. Rather, there are many terms that are currently used by scholars that try to depict the same category of migrants, for example by referring to them as: *'undocumented'*, *'irregular'*, or even *'illegal'* (Bloch & McKay, 2016, p.6). Given that the vulnerability of this category of migrants is subject to the volatility of their status, which is ultimately a *'social, political and legal construction'*, it can change over time depending on, among other things, political circumstances (Bloch & McKay, 2016, p.6). Because the word 'irregular' emphasises the precariousness of their legal status (which is not fixed, but irregular and volatile; their status can be temporarily legal, then change to illegality and back again), I have decided to adopt the term 'irregular migrants', as opposed to undocumented, which is a more static interpretation.

An important consideration, in line with the protest school, is that it is questionable to what extent the migratory status is the only problem underlying irregular migrants' inaccessibility to human rights. Rather, it is likely that their migratory status intersects with other characteristics that often define this group, which ultimately leads to a state's aversion to realize their human rights, whether consciously or unconsciously. In the words of Dembour and Kelly (2011, p.9):

'If the access of migrants to human rights is problematic, it may not be so much because the people we are talking about are migrants, but because they are predominantly poor and black, linked to a long history of political and economic exploitation. These migrants are denied rights, not so much because they have crossed an international border some time in their lifetime (many of us in the cosmopolitan 'elite' do this regularly without any consequent problem), but because they are politically and socially marginalized'

Despite this marginalization, it is important to acknowledge that irregular migrants have agency and should not solely be seen as 'victims'. Although legal and political circumstances often shape their lives in a negative way, they themselves have the power to change their lives and circumstances too. According to Bloch & McKay (2016, p.7) this individual agency and power is essential to take into account in academic analyses on irregular migrants. However, irregular migrants often do not mobilize out of fear to draw attention to their irregular status. Moreover, in line with this: *'(...)immigrants face particular problems in political organisation. The particular conditions in which the most marginalised migrants live mean that they lack the moral, political and economic resources for this struggle'* (Dembour and Kelly, 2011, p.9). Given this context of marginalization, it is likely that in those places that have been able to create inclusive health policies, irregular immigrants interests' have been strengthened by CSOs and other political agents, who may have politically mobilised in their name or alongside them.

Having further clarified the category of migrants that will be focused on in this thesis, I will now link the above to theories to citizenship and nationalism. To understand the situation and vulnerability in which irregular migrants live, the connection between human rights and citizenship (nationalism) is of key significance. The reason for this being that in practice human rights are too often merely protected by states in relation to particular citizenship (namely citizenship of the particular country) (Thompson, 2013). The latter is why the principle of universality is relevant in relation to irregular migration, given that this notion goes beyond the pathological connection between human rights protection and citizenship. In order for one to grasp these linkages, we must engage with, among other things, the history of state building and the evolution of our understanding of citizenship and nationalism.

Ever since its conceptualization in Roman times, and before that during the time of the ancient Greeks, citizenship encompassed an element of exclusion. After all, in Ancient Athens, for example, only a certain segment of the population was granted citizenship, the non-citizens being the women, slaves and children (Delanty, 2000, p.11). Up until medieval times, citizenship was still conceived of as a relationship some entitled individuals had to cities, and importantly not to nation states. In other words, the word did not yet refer to nationality in any way (Delanty, 2000, p.12). However, over the centuries a shift can be observed in the way people have come to understand citizenship and the political community to which it belongs.

Whereas the term citizenship initially signified membership of a city (-state) with specific rights as well as corresponding duties, the process of state building from the 16th century onwards drastically changed our conceptualization of citizenship (Delanty, 2000, p.12). At this time, the increasing power of the state challenged the urban relationships that people had attained over the centuries. According to Delanty (2000), this process of state building led to the assimilation of difference and the effective naturalization of those who were deemed (culturally) different (assimilating those whom are different to create loyalty with the state). Delanty (2000, p.97) refers to the type of nationalism that accompanied this process of state building as 'old nationalism', which according to him was based on patriotism. During this period, the emphasis was placed on the principle of equality (e.g. the principle of *égalité* in the French revolution), since it proved instrumental to state building.

In contrast to this, over time citizenship has moved toward the recognition of difference and away from the principle of equality (Delanty, 2000, p.10). According to Delanty (2000) and Castells (1997) this is because nationalism has lost its connection to state building. According to Delanty (2000, p.97) a new kind of nationalism has evolved in recent times, coined 'new nationalism', a type of nationalism that is less inclusive than the old kind of nationalism because it has replaced the idea of equality with the idea of difference. The above is in line with Manuel Castells' observation that nationalism is increasingly reactive instead of pro-active; it is increasingly about defending cultural institutions, rather than about state building (Castells, 1997, p.31; Sabanadze, 2010, p.25). In other words, it is primarily becoming a cultural and ethnic kind of nationalism, rather than a political kind of nationalism (Sabanadze, 2010). Arguably, Delanty (2000, p.95) states that new nationalism is an expression of social discontent, rather than of a patriotic sentiment. One of the ways in which this is reflected is through feelings of extreme hatred toward immigrants. Whereas the old nationalism tried to assimilate otherness, new nationalism defines itself by denouncing difference without the assimilating effort. In Delanty's words: *'It [new nationalism] is more a matter of xenophobia than of jingoism (...) Nationalism today no longer appeals to ideology but to identity and material interests'* (Delanty, 2000, p.97).

In a context of new nationalism, two prevailing understandings of citizenship can be identified: a classic understanding of citizenship connected to both the market and the state and encompassing a legal status (which is therefore more exclusionary), versus an understanding of citizenship that is defined more substantively (and thus less formally) through participation in a political community (Delanty, 2000, p.9). I would argue that the contention that surrounds the first type of citizenship might open up spaces for alternative expressions of citizenship and democracy (such as the human right polity, which will be introduced shortly). In other words, the latter kind of citizenship, the less formal one, allows for more local notions of citizenship, since residing and participating in a political community can be substantively exercised and realized at lower levels, irrespective of a particular legal or formal status.

Looking at the relationship between rights and citizenship, it should be noted that the rights attached to citizenship are bound to the political community to which it belongs. In other words, citizenship rights are much more particularistic, whereas human rights are more universalistic (Delanty, 2000, p.69). Over time, the rights of individuals as human beings and the rights of citizens have diverged and this divergence is paramount to our understanding of the inhumane situation of the irregular migrant (Delanty, 2000, p.68).

In her famous work *The Origins of Totalitarianism*, Hannah Arendt - one of the most renowned political philosophers of the twentieth century - criticizes human rights for its lack of enforcement potential and for its protection mechanisms ultimately depending upon the will of nation states (Arendt, 1973). Securing rights, she argued, only truly happens through membership of a political community, through citizenship. At this point, she argued that the inadequacy of human rights is reflected by the non-realization of irregular migrants' human rights (Arendt, 1973). She emphasised the fact that those irregular migrants whom are stateless are effectively without protection of the political community. After stressing the gravity of the extent of marginalization of stateless people by arguing that even slaves had a place within the community, albeit it was one of extreme exploitation and marginalization, Arendt argues:

'Not the loss of specific rights, then, but the loss of a community willing and able to guarantee any rights whatsoever, has been the calamity which has befallen ever-increasing numbers of people. Man, it turns out, can lose all so-called Rights of Man without losing his essential quality

as man, his human dignity. Only the loss of a polity itself expels him from humanity' (Arendt, 1973, p.297).

Although not all irregular migrants are stateless, they too often lose their polity, albeit in a more substantive sense by being physically apart from their country of origin that is unable or unwilling to protect them in the country where they reside. Despite the negative evaluation of Hannah Arendt dating back to the first publication of her book in 1951, it should be remarked that novel mechanisms of protection have arisen that move beyond the nation state system (treaties, novel monitoring bodies and systems, regional human rights mechanisms), so that one could argue that a certain form of protection is nowadays also guaranteed for irregular migrants. Stronger still, human rights are one of the only sources of protection for irregular migrants in our current societies as they are frequently socially, politically and economically marginalized by the host societies (Bloch & McKay, 2016). However, at the same time, the human rights regime does not suffice in effectively realizing human rights on the ground. Ultimately, therefore, the problem remains that the effective realization of human rights is still very much dependent on the Westphalian world order. Those who do not have a place within this world order, being de-facto stateless or undocumented, are the 'wasted lives' of our time, to borrow a telling term by Zygmunt Bauman (Bauman, 2013). They are a testament to the need of better human rights protection, and their marginalization is a thorn in the eye for those with a belief in human dignity.

1.3 Contentious Governance and the Making of Human Right Polities

Perhaps it is this thorn that has resulted in protest from lower levels of government, and the opening up of spaces for alternative expressions of citizenship and democracy. Garcés-Mascreñas and Chauvin (2017) emphasise that with regard to irregular migrants the local level of government is of vital importance since this is where irregular migrants can still be included in societies that uphold overall exclusionary policies. The increased attention to the local level as a beacon of hope fits within the more general shift within academia to stop disregarding space as non-influential on the social, economic and cultural. This on-going spatial turn signifies the increased attention of the relationship between space and society within academia.

Unmistakably, it is at the local level where interaction takes place between and among citizens and non-citizens, where one is closer to everyday realities and where irregular migrants come into contact with support networks of civil society and street level bureaucrats (Garcés-Mascreñas and Chauvin, 2017, p.52). It has been argued that these street level bureaucrats play an essential role in the incorporation of irregular migrants, for it is their humanitarian and professional concerns that lead them to include them (Garcés-Mascreñas and Chauvin, 2017, p.52). In other words, street-level bureaucracy has been put to the fore as one of the reasons why irregular migrants have been granted access to municipal services, and health care for that matter (e.g. professionals such as doctors unwilling to ignore their professional ethical codes and thus treat patients anyway).

Perhaps not surprisingly, reality on the local level is more complex than this, as it turns out that it is not merely sunshine on the local level either. As Ambrosini (2013) has shown by means of a case study in Italy, local authorities sometimes also enact more rigid and exclusive policies that affectively exclude migrants from economic, social and cultural life. Whereas scholars have given ample attention to the inclusive nature of local levels of government, they have largely ignored the restrictive nature that sometimes also germinates from the local level (Ambrosini, 2013). Moreover, in line with this, they have also ignored the divergence among local (regional) levels in terms of inclusive versus exclusive policies. Despite the attention on the local and national level, it is still unclear what factors underlie the uneven realization of progressive versus regressive policies on regional levels in a comparative sense. It is the latter that this thesis tries to shed light on.

It is not just street level bureaucrats that may challenge exclusionary laws. As has been outlined in the introduction, various regional and local governments actively challenged Royal Decree-Law 16/2012, which restricted access to healthcare services for irregular migrants. In order to make sense of this contestation between governmental players, the concept of 'contentious governance' can provide insights. First and foremost, the concept recognizes that the government - or the state for that matter - is not a unified actor or entity; they may have different and competing competencies. This is in line with the principle-agent theory/problem (Fuentes, 2015, p.290), which argues that agents – in this case the autonomous communities - may diverge from decisions taken by the principle (the Spanish state) due to the agency that the agents have and the idea that the decisions taken by the principal do not always coincide with the interests of the agent. It is therefore better to think of the state as composed of a myriad of actors who compete for power on a variety of issues, among which immigration policies and health policies. This is captured by the emphasis on 'governance', as opposed to government. The relatively recent emphasis on governance in political science has been broadly documented starting from the 1990s (Rhodes, 1996). The increased autonomy of governmental actors as a consequence of, among other things, decentralisation, and the role of networks of self-organizing civil society in designing policies are exemplary of the shift from government to governance (Verhoeven and Bröer, 2015, p.4; Rhodes, 1996, p.666).

In line with this shift toward governance, Hajer (2003) has argued that policies are increasingly being developed without the presence of a clear-cut polity. Policy is increasingly being developed beyond and within tradition polities that define the nation state. Issues like climate change are being deliberated upon in an institutional void, Hajer (2003) argues, a space in which we lack the established institutions, rules and norms to properly deal with an issue. The term institutional void does not merely relate to policies that are designed in unconventional spaces of governmental players, it also relates to the involvement of other actors in designing policies, such as companies and civil society organisations. In other words, given the myriad of competing actors at hand, the polity has lost its stability and should currently be conceived of as something discursive. As such, it has become an interesting unit of analysis (Hajer, 2003, p. 176).

In line with the idea of polities as something discursive, I argue that we are witnessing, among other things, the emergence of novel polities, among which 'human rights polities'. According to Corry (2010, p. 159) a *'polity-structure exists when a group of units become oriented towards the governance of a common "governance-object"'*. The latter can be defined as an object that is constructed as real, distinct, malleable and subject to political action, for example, constructs such as "France" or "the climate"'. Given my positioning in the human rights field, I would argue that human rights are real constructs; they exist. They are enshrined in declarations and treaties that are tangible, and beyond that the human rights idea is, I believe, just as much a reality as the idea of the state, with reference to Corry's example, the idea or construct of 'France'. Moreover, human rights are not only real, they are malleable, since political agents can shape their realization and/or non-realization, just as much as the climate can be influenced by unsustainable behavior, making both conditional on political action.

I will define human rights polities as those political entities (e.g. cities and regions) that uphold human rights in contestation to existing hierarchies; it is not just the presence of human rights policies that results in the creation of the human rights polities within (and beyond) the nation state, but the active defiance of hierarchy, a process of intra-governmental disobedience if you will, that was required for these policies to be enacted, making them a distinct group of units oriented towards a common governance object. Contention is a vital component of a human right polity, depicting the true commitment of the group of units to human rights protection. In other words *'the*

polity is constructed, dynamically, through contestation in the political process, with occasional involvement by courts' (Rodriguez, 2010, p.31).

Since the state is not the obvious polity anymore (Hajer, 2003), in relation to human rights realization, the state is perhaps also not the appropriate unit of analysis anymore, as some areas within a state may realize rights, whereas others may not. This reflects the idea of human rights polities; islands of a politics of human dignity within (and perhaps beyond) nation states that offer a countermovement to the convulsing politics of a new type of nationalism that seems increasingly xenophobic.

Table 1: Overview of Different Political systems

| | Political systems (sets of units that interact enough to have to take each other's actions into account) | | |
|---------------------------------|--|--|---|
| | Hierarchy | Anarchy | Polity |
| Constitutive feature | Existence of a sovereign | Absence of sovereign power and absence of common governance-object | Existence of a common governance-object |
| Ordering principle | Super – and subordination between subjects | Coordination between subjects | Orientation towards common governance-objects |
| Organisation of political space | Vertical | Polar | Concentric |
| Principle of membership | Centralised inclusion/exclusion | Systemic mutual recognition | Decentralised identification |
| Variable dimensions | Centralisation/ Decentralisation of power | Unipolar/multipolar | Dense/dispersed |

Source: Corry (2010, p. 174)

The emergence of human rights polities goes beyond the development and emergence of 'human rights cities', a phenomenon that has been increasingly explored in academia over the past few years (Oomen, & Baumgärtel, 2014; Soohoo, 2016; van den Berg, & Oomen, 2014). In other words, it should be remarked that although human rights cities may constitute a human rights polity, not every human rights city would necessarily constitute a human rights polity, since one can only talk about a distinct polity when in its efforts to protect human rights it moves in contestation with state policies. In that sense, a human rights polity is relational to existing hierarchies. Moreover, human rights polities can be local, but also regional (or supranational), which makes it a relevant term in relation to provinces and or states within (federal) countries.

Within the debate around human rights cities, the role of local levels of government in the realization of human rights on the ground has been extensively recognized (Oomen, 2015; Oomen, & Baumgärtel, 2014). In Europe, although some scholars mention 'regional authorities' in line with local authorities (Oomen, 2015; van den Berg, & Oomen, 2014), the academic focus has primarily been on cities and municipalities, as opposed to regions such as provinces or states within countries. This is somewhat in contrast to scholarly work in the United States and Canada, where for example federalism has been more extensively analysed in relation to human rights implementation (Cameron, 2002). Importantly, it is essential to stress that it is relevant to distinguish between the local and regional levels of government, and thus to not throw them on one heap, given that their competencies may vastly differ and their efforts to protect human rights may be distinct.

In relation to the realization of human rights 'on the ground' or in practice, scholars have stressed the need to 'localize' human rights; local experiences and understandings of human rights (violations) must feed into global human rights regimes (De Feyter, 2007). By extension, and in addition to the localization of human rights, I believe it to be relevant for the institutional makeup of our societies to feed into global human rights regimes. Currently, human rights treaties and instruments are very state centric and do not reflect the complexities of the institutional makeup of our societies that have moved away from 'government' to 'governance', from centralized hierarchy toward decentralization, federalism and the involvement of CSOs.

In line with this, I believe it to be relevant to explore an idea I would like to coin 'the democratization of human rights instruments'. That is to say, formally and informally increase the active participation of lower levels of government (regional and local political entities with certain competencies and thus responsibilities in the realization of human rights) in human rights mechanisms, for example by allowing them to join human rights instruments and mechanisms and co-sign treaties (e.g. grant them treaty making capacity). Although democratizing human rights instruments may lead to fragmentation of human rights implementation within states, it may also lead to more positive developments such as the localization of human rights and (more institutionalized) pressure from below to take human rights more seriously at national levels; thus challenging the idea of human rights as international impositions on state sovereignty (Oomen, 2015, p.407). Although beyond the scope of my thesis as further research on this topic is needed, in order to combat fragmentation, it should be remarked that democratizing human rights instruments should not substitute state protection, but complement it. More concretely, elements of 'co-operative federalism', which has allowed provinces in Canada to participate in the making and implementation of treaties, as well as in the reporting of compliance (Cameron, 2002, p.49), could for example be expanded, and adapted to fit non-federal, yet highly decentralized states (like Spain).

Importantly, given the scope of this thesis, I will not be able to argue with full certitude that human right polities exist by merely looking at the human right to health, nor that there is a need to democratize human rights instruments without any further (future) research on the topic in terms of advantages and disadvantages. However, given its contention, looking at the human right to health does allow me to shed light on the making of a human right polity (and the potential of democratizing human rights instruments); so even if human right polities do not exist in the most encompassing way with reference to all rights, I will try to argue that they are emerging.

At this point, in order to make sense of human rights polities, it is necessary to understand the formation of policies. In order to do so, one needs to understand both the processes behind policy change and policy persistence. Within policy and governance studies, it is the concept of path-dependency that relates to the persistence of policies over time and the difficulty of creating change. To understand how health policies moved in different directions, and how human rights polities are being made and unmade, it is necessary to look into both the static and dynamic processes underlying policy formation, among which contention.

But how can one analyse these processes? Given the shift to governance, it is not hard to grasp that contention can take place within and among governmental actors themselves. In general, '*contention is commonly understood to be a process of claims making by non-state actors in which the state is either the target of or a third party to claims*' (Verhoeven and Bröer, 2015, p.3). However, Verhoeven and Bröer (2015, p.3) stress that governmental actors, such as political parties or local levels of government, can also be the '*initiators of claims*' in order to bring about changes in policies and laws (Verhoeven and Bröer, 2015, p.3). In some cases, lower levels of governments can even demonstrate social movement like behaviour, e.g. when facilitating social mobilization against a national law or decision (Verhoeven and Bröer, 2015, p.2). In order to analyse contentious governance, three

dimensions of contentious governance can be identified, namely: contentious performances, the formation of collective actors, and political opportunity structures (McAdam, & Tarrow, & Tilly, 2009)

The concept of contentious performances, as defined by Tilly and Tarrow (2007), is related to the broader concept of claims-making between political actors and it encompasses the *'relatively familiar and standardized ways in which one set of political actors makes collective claims on some other set of political actors'* (p.11). In contrast, a contentious 'repertoire' is the specific collections of contentious performances that a particular political actor or set of actors uses and knows (Tilly and Tarrow, 2007, p.11). In other words, contentious performances make up a repertoire.

Social interaction and narratives may underlie these contentious performances. According to scholars, social interaction is an essential element influencing why people join collective action (Passy, 2009). That is to say, in relation to the formation of collective actors, social interaction is of importance. According to Passy (2009, p. 356): *'scholars stress that social interactions shape people's cognitive map continuously which in turn facilitate (or not) their commitment to contentious politics'*. However, it is not just social interaction that defines contentious politics. Rather, it is the combination of narratives and social interaction that contribute to collective action (Passy, 2009, p.356). Interactions that make up social action are both improvised and routinized. That is to say, it entails a certain element of agency and a trial and error process, but the existence of social scripts and shared knowledge and understanding also leads to reproduction and routines (Passy, 2009, p. 356-357).

As I have shortly stated, besides these contentious performances, other dimensions of contention are also worthy of analysis. Among these are political opportunity structures (McAdam et al., 2009). Political opportunity structures are the properties of a regime that may affect the extent to which contentious performances are successful (McAdam et al., 2009, p.263). In other words, they are the institutional and political openings that are available to social movement actors to influence decision-making. Although scholars have interpreted political opportunity structures in many ways, they include, amongst other things, the following: *'the multiplicity of independent centers of power within the regime, the regime's openness to new actors, the instability of current political alignments, the availability of influential allies or supporters for challengers, the extent to which the regime represses or facilitates collective claim Making'* and the changes in these factors (McAdam et al., 2009, p. 263). When analyzing contention, not only the performances must be looked into, but also the structures within which these performances enfold, as these may determine the success of claims making performances.

In addition to political opportunity structures, another dimension worthy of analysis is the formation of collective actors (McAdam et al., 2009). By looking into the formation of collective actors, which is more relational in nature, one may shed light on the dynamics of the contention at hand, as opposed to looking solely at the structures on the one hand and performances on the other.

In relation to the analyses of contentious politics, different methodological tools and theoretical traditions are of importance. There are three main theoretical traditions underpinning the analysis of contentious politics, namely the political process approach (structural), the rational choice perspective (mobilization of resources), and the constructivist perspective (framing) (McAdam et al., 2009, p.265). McAdam et al. (2009) make a strong case for a synthesis among and between these perspectives in order to properly be able to analyse contentious politics. In so doing, they propose an approach that they entitle: *'the mechanism-and-process approach'* (McAdam et al., 2009, p.266), which relates to the analysis of the mechanisms of contention that have already shortly been touched upon. Elements of this approach will be incorporated in my case analysis, which I will methodologically work out in the next chapter. In relation to performances, political opportunity

structures and the formation of collective actors, some mechanisms can be identified that are reflected in all processes of contention (McAdam et al., 2009). By looking into these mechanisms and by analysing them, one may unpick the process of contention and move beyond epistemological myopia.

According to McAdam et al. (2009) contentious processes encompass at least five major mechanisms. One of these is *'brokerage'*, which they define as the creation of new connections among groups or parties that weren't (well) connected before (McAdam et al., 2009, p.266). Since in any campaign diffusion of ideas requires social movement actors to connect with previously unconnected groups, and since brokerage facilitates coordination and reduces communication costs, it is a well-known phenomenon in contentious politics. Besides brokerage, contentious politics also encompasses a process called *'identity shift'*. This refers to the way in which people with different identities and social roles create and adopt a distinct and common identity, albeit temporarily (McAdam et al., 2009, p.266). Within this process, *'boundary formation'* is of importance, which signifies the *'the creation of an us–them distinction between two political actors'* (McAdam et al., 2009, p.266).

Another process of contention involves the in- and exclusion of actors. Whenever a less powerful actor is drawn toward the center of power through a process of contentious politics and is thus included, as opposed to excluded, we can speak of a process of *'co-optation'* (McAdam et al., 2009, p.). Lastly, among other things to gain support, social movement actors frequently aim to spread their ideas through different media outlets, among which social media. Contentious performances and ideas often spread from one place to another, turning local contentious issues into regional, national or international ones. The process depicting this dispersion of contention is called *'diffusion'* (McAdam et al., 2009, p.266).

1.4 Conclusion

Irregular migrants are a vulnerable group of people that often do not enjoy access to human rights, among which the human right to health. The rise of a new kind of nationalism has aggravated the realization of human rights for irregular migrants at a national level given its xenophobic character. The principle of universality is under pressure due to a strong linkage between citizenship, nationalism and human rights protection; those without appropriate citizenship risk being stripped of their rights by nationalist forces. However, within this development, a contrary development can be identified, in line with the shift away from *'government'* to *governance*, which is rise of *'human rights polities'*.

The emergence of human rights polities goes beyond the development and emergence of human rights cities, given the latter's exclusive focus on the local level and the fact that contention does not presuppose it. Human rights polities are (local, regional or supranational) political entities less subject to chauvinistic, new nationalism that develop policies, contrary to the state's wishes, to protect human rights [and include irregular migrants]. This process constitutes a process of contentious politics, which can be analyzed through the concepts political opportunity structures, the formation of collective actors, and contentious performances. Within these dimensions of contentious governance, mechanisms can be identified which may shed light on the dynamics of contention.

Now that the theoretical framework has been provided, the methodology will be elaborated upon, which will be followed by the case analysis.

Chapter 2: Research Methodology

2.1 Research Question

In order to make sense of the factors underlying non-compliance of certain autonomous communities in relation to RDL 16/2012, and based on the theoretical framework, I believe it to be relevant to look into political opportunity structures, the formation of collective actors and contentious performances.

To answer the more generic question of why some autonomous communities act in accordance with the universality of the human right to health, whilst others follow the discriminatory national legislation implemented in 2012, I have formulated, in relation to the theories and concepts outlined in the theoretical framework, the following research question:

‘How do political opportunity structures, the formation of collective actors, and contentious performances by regional governments and civil society organizations enable and/or restrict the provision of healthcare to undocumented migrants in Spain, and how does this relate to the idea of emerging human rights polities?’

To answer the research question at hand, this thesis will be informed by a range of data collection methods and methods of analysis. These will be outlined accordingly.

2.2 Methods of Data Collection

In terms of the methods of data collection, it should be noted that this thesis encompasses literature research and a case study. In the literature research part, I engaged with academic literature from Public Policy and Human Rights related fields, whereas in the second part of the thesis, besides literature research, a qualitative content analysis has been conducted to analyse the political opportunity structures, contentious performances and the formation of collective actors.

In relation to a qualitative content analysis, data can be derived from a variety of sources. That is to say: *‘text data might be in verbal, print, or electronic form and might have been obtained from narrative responses, open-ended survey questions, interviews, focus groups, observations, or print media such as articles, books, or manuals’* (Hsieh & Shannon, 2005, p.1278). To understand why some regions adhere to the human right to health more than others, the claims made by the different governments were analysed in light of political colour, political opportunity structures, the formation of collective actors and contentious performances. The main part of the qualitative content analysis encompasses an analysis of all the main claims (for defying RDL 16/2012) made in publically accessible legislative & administrative documents of regional governments in the period 2012 to 2015, and 2015 to 2018 [two distinct governmental cycles].

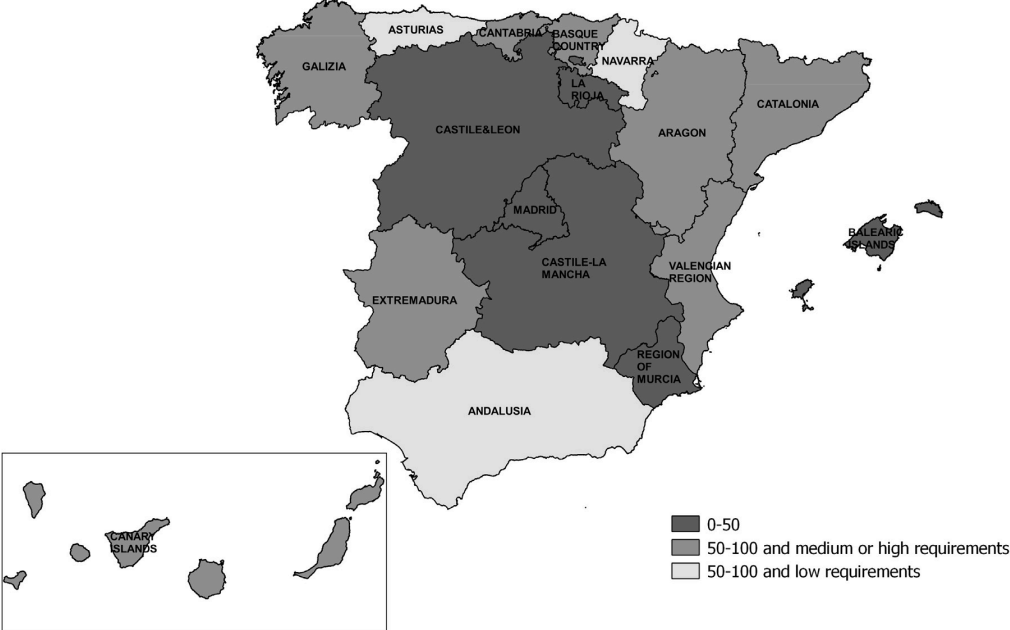
In total 34 relevant legislative & administrative documents were analysed, differing in their degree of authority (see annex 1). The legislative & administrative documents have been obtained using the matrix containing all the norms and laws defying RDL 16/2012 drafted by the civil society platform *‘Yo Sí, Sanidad Universal’*, and the accuracy of this matrix has been verified by comparing it with the norms and laws found by Cimas et al. (2016). In addition to this, the websites of the regional health ministries were consulted and scrutinized for the presence of norms and laws extending RDL 16/2012 using the combining search terms *‘la asistencia sanitaria’* and *‘inmigrantes sin papeles’* or *‘inmigrantes irregular’* (e.g. the existence of the announcement of more inclusive healthcare in Murcia was retrieved in this way). The resolution drafted in Castilla y Leon on the 12th of June 2018

found in this way has not been analysed since it has been drafted after the recent governmental change at national level (“Programma Assistencial,” 2018).

Importantly, autonomous communities have issued documents with a different degree of (legislative) authority. Laws have been implemented in five autonomous communities; ‘orders’ have been created by three autonomous communities; resolutions by one, and instructions by 10 autonomous communities (for an overview, see Annex 1). The differences between ‘orders’, ‘resolutions’ and ‘instructions’ lies in the degree of authority [the orden being most authoritative (after laws), followed by resolutions, and lastly instructions] (Sanz, 2012), although all are norms which have led to the inclusion of irregular migrants to the healthcare system. Instructions are documents that tend to be complementary to normative positions and often clarify points of the regulations to which they refer (Sanz, 2012). For the period until 2015, health inclusiveness has been based on Cimas et al., (2016), for the period following 2015, for which no health inclusiveness scores exist, I estimated the health inclusiveness based on the requirements and the coverage established in the norms and laws, comparing these to the requirements and coverage of the norms and laws from the preceding period and the health inclusiveness attributed to it by Cimas et al. (2016) (see footnote page 34 for more information).

I have complemented the analysis of legislative & administrative documents with personal accounts of policy makers and other involved actors through conducting interviews. This constitutes the other part of the qualitative content analysis. Given the limited scope of my thesis, I had to select which regions to focus on, and in so doing upheld a combination of two different case selection techniques, namely the ‘deviant’ and ‘diverse’ case selection methods as elaborated upon by Seawright and Gerring (2008, p.300). In order to arrive to the most meaningful conclusions, I believed it to be necessary to focus on those regions that had a political landscape similar to that of the national context in one of the periods under scrutiny. In other words, political colour functioned as my control variable. Moreover, to make any meaningful comparison, I believed it to be relevant to select regions that differed in health inclusiveness in terms of irregular migrants' access to healthcare (so regions that deviate from Royal Decree-Law 16/2012 and those that do not).

Figure 2: Scores of regional health care policies after RDL 16/2012 (until 2015)



Source: Cimas et al. (2016, p. 390)

Based on the scores attributed to the regions in terms of health inclusiveness toward irregular migrants (Cimas et al., 2016), I decided to focus on the autonomous communities of Navarra and Cantabria. Navarra was by far the most inclusive autonomous community in the period 2012-2015 as it scores 100% in health inclusiveness as calculated by Cimas et al. (2016). Thus, it deviates most from RDL 16/2012. Moreover, before 2015, a political party ruled the region with a similar political colour than that of the Partido Popular (PP), namely the Unión del Pueblo Navarro (UPN), which until 2008 actually represented the PP in the region (Artola, 2008). In terms of regions ruled by the Partido Popular, Cantabria was among those that deviated most in terms of health inclusiveness in relation to other regions ruled by the PP, given that it scored 68.5 % in health inclusiveness in 2012-2015 as opposed to the 35% average in a PP region (Cimas et al, 2016). I aimed to also interview the government of La Rioja or Castilla-La Mancha, since these regions were ruled by the PP and scored 0% in health inclusiveness, making them most compliant with RDL 16/2012 (Cimas et al, 2016). Unfortunately, despite various emails and phone calls, I did not gain access to government officials in these regions.

In the end, semi-structured interviews were conducted with a health director in the regional government of Cantabria and a jurist/legal advisor of the health department of the regional government of Navarra (see Annex 4). Both worked on the implementation of RDL 16/2012 at a regional level. In relation to these two interviews, I have received support from two translators. In addition to the interviews with the two regional governments, I have conducted an interview with the advocacy officer of the civil society organisation that led the fight against RDL 16/2012, *Medicos del Mundo*. Thus, in total, three interviews have been conducted in Spanish and English with informants, lasting around 1.15 hours each, all of which were recorded with the interviewees' permission. Whereas I transcribed one interview myself, the Spanish interviews were transcribed and or translated by a translator, a former journalist and current human rights and policy student, Maria Clara Calle. The methodological impact of translation and language limitations will be touched upon in the discussion section of my thesis. Naturally, the autonomous communities in Spain are very different in various respects, so I acknowledge that there are some shortcomings by having only interviewed two regional health ministries; it will be difficult to generalize any claims made by the government officials interviewed, but in combination with the qualitative content analysis they have provided me with insights. The limitations on the interview and case selection are discussed in the 'discussion' section of my thesis.

Lastly, a relevant note to make is that the writing of the theoretical framework has been subject to an iterative process; I have been sensitive to different and/or new ideas depending on the findings of the interviews and the qualitative content analysis. In a way the theoretical framework has been partly informed by the case analysis, although pre-existing ideas based solely on literature research have shaped most of it.

2.3 Methods of Analysis

At this point, given that I have argued that politics are discursively constructed and that social interaction and narratives are of importance in relation to contentious performances and the formation of collective actors, I am first and foremost interested in the production of meaning, which belongs to the constructivist paradigm. On the other hand, given that I recognize that performances and group formation takes place within certain established structures, I am also interested in identifying and analysing the political opportunity structures, as described by McAdam et al. (2009). In contrast to analysing performances, which belongs the constructivist paradigm, analysing the political opportunity structures would coincide more with a political process approach. Importantly, therefore, it is relevant to point out here that this thesis will be upholding both a meaning production approach (performances) and a political process approach (political opportunity

structures). These belong to different epistemological and ontological traditions, namely an interpretivist versus a more positivist paradigm.

Although some may believe that both approaches are not mixable, I believe they can work complementary, among other things with reference to McAdam et al. (2009) who have specifically called for the need to combine epistemological traditions to understand contentious governance. These authors proposed the mechanism-and-process approach precisely to try and find a synthesis between different epistemological traditions. I believe that neither the constructivist nor the political process models have the sole answers in understanding processes of contention. Rather, new insights can be acquired when different epistemological traditions are combined. By being explicit and acknowledging that I'm mixing different research traditions, and by following elements of the approach designed by McAdam et al. (2009), I aim to resolve the tensions related to mixing different philosophical underpinnings of research.

Despite the fact that McAdam et al. (2009) advocate for the importance of analyzing mechanisms of contentious episodes, they haven't really worked it out in a methodological way. Although they mention ethnographic, quantitative and naturalist experiments as potential methodological tools to analyze contention, they state other methodologies can also be used to analyze contentious governance. After careful consideration, I decided to analyse contentious performances, political opportunity structures and the formation of collective actors in relation to mechanisms by means of a qualitative content analysis, as outlined by Bengtsson (2016) and Hsieh & Shannon (2005). A qualitative content analysis can be described as follows: *'a research method for the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns'* (Hsieh & Shannon, 2005, p.1278). I have decided to opt for a qualitative content analysis, in contrast to for example framing theory which is traditionally used to analyse contentious performances, because I believe the general and broad nature of a qualitative content analysis enables me to use it for different purposes, so both for identifying political opportunity structures and analysing performances and the formation of collective actors. Given the scope of this thesis, I will not pay attention to the resource mobilization approach, although I acknowledge that resources are of importance in any process of contention.

In relation to the qualitative content analysis, and using the coding software MAXQDA12, four different steps were followed which can be summarised as *'decontextualisation, recontextualisation, categorisation, and compilation'* (Bengtsson, 2016, p.11). In what Bengtsson (2016) has coined the decontextualisation phase, I have read the transcribed interview data and the policy documents under scrutiny very carefully and formulated 'meaning units', which relate to the pieces of text that contain insights. In a process of (semi) open coding I have subsequently attached (sub) 'codes' to each meaning unit. These (sub) codes were the themes or concepts that were identified when breaking down the meaning unit into its essence; this is why this phase of the research has been coined 'decontextualisation' (Bengtsson, 2016). Codes were derived from the transcribed interviews and policy documents semi-inductively. The reason that I relate to this latter process as semi (!) inductive/open coding is because of the theoretical framework and literature research that presubscribed the coding process and which may have shaped and influenced what I looked for; it will therefore not be fully inductive. I think it is important to recognize the implicit deductive phase that may have influenced the coding process since it may have biased what I looked for; *'researcher must take into consideration his or her "pre-understanding", both in the planning process as well as during the analyzing process, in order to minimize any bias of his/her own influence'* (Bengtsson, 2016, p.8).

In the recontextualisation phase, and in line with the necessity to repeat the coding process multiple times due to the possibility for inductive codes to change as one's interpretations may evolve

(Bengtsson, 2016, p.12), I re-read the (transcribed) texts to identify whether any important information was left unlabelled or wrongly labelled. Then, I either included the left over pieces of text by linking them to a meaning unit and (sub-) code, or discarded them whenever I considered the information not relevant for my research question. In the categorisation phase, I grouped the meaning units and their (sub-)codes into certain categories or themes by further condensing the information (Bengtsson, 2016, p.12). These then became my 'main codes'. Lastly, in the compilation phase, I analysed these categories or 'main codes' in relation to their meaning units and (sub-) codes. I did so in a manifest way. In contrast to a latent analysis, I aimed to '*stay closer to the meaning and contexts*' (Bengtsson, 2016, p.12), and used the interviewees' explicit words and statements, as opposed to looking for implicit meanings of their statements. Whilst doing so, I have paid special attention to the mechanisms identified by McAdam et al. (2009). To facilitate the compilation phase I created tables, using the coding software MAXQDA, so that I got an overview of the meaning units, (sub) codes and categories (main codes) and was able to analyse these in an easier way. In the table below, the column 'condensed meaning unit' illustrates the kind of reduction I made by myself, although this is not reflected in the MAXQDA tables.

An example of this would be the following:

| MEANING UNIT | CONDENSED MEANING UNIT | (Sub-) CODE | CATEGORY (Main Code) |
|---|--|--------------------------------------|----------------------|
| In 2012, at different regional levels several platforms were created and the project REDER that I am coordinating is saying precisely to gather all those regional initiatives under one big umbrella | REDER created as the umbrella organization of regional platforms that originated in response to RDL 16/2012 | Uniting social movement actors | Role of CSO |
| We tried to articulate at a regional level alternatives working with regional governments but also...working with regional governments and advocating at regional governments to ask them to change the regional norms that provide access to the people. | Medicos del Mundo cooperates with regional governments and advocates changing laws and developing alternatives to increase access. | Political advocacy at regional level | Role of CSO |
| [...] also working at regional level within our offices to provide migrants with information because one of the main offence that happened because of this change of law was that no-one was informed about what were the real consequences, what were the rights that the people were still maintaining despite RDL. There was a whole confusion and Medicos Del Mundo tried to fill that gap by providing information to the people. | Regional offices of MDM provide information to migrants about their rights. | Provide information | Role of CSO |
| Not just information, but also health, because as we were talking the implementation of RDL has not been adequate and even the exceptions of RDL were breached, as in most cases, and so the role of Medicos del Mundo was also, and also other organisations, but Medicos del Mundo did it, was accompanying; going with the people... if a pregnant woman was rejected at the hospital then Medicos del Mundo would go with that pregnant woman to the hospital and say that according to the law this woman has a right to healthcare so you have to treat her. | Regional offices accompany migrants to ensure access to health | Access to healthcare | Role of CSO |

Twelve main codes were identified during the (semi-) inductive coding process of the legislative & administrative documents, namely: principle of universality and equality, principle of efficiency/effectiveness, principle of (economic) costs, (breach of) competencies, (Constitutional) right to health, human rights treaties and international declarations, national health laws, regional laws, public/collective health (risk), health irregular migrant, practical reality, and lastly, social program.

The codes identified during the coding process of the three interviews were slightly different. In line with the previous process, twelve main code were identified during the (semi-) inductive coding

process of the three interviews, namely: role of CSO, RDL 16/2012, mobilization of collective actors, principle of (economic) costs, right to health, political color, public health, competing interests, (breach of) competencies, ACs contentious performance, healthcare provision in practice, and lastly, political opportunity structure. The latter code depicts the deductive element in the coding process, as the theoretical framework informs it.

The overall analysis of the coded documents and interviews has been placed in a context of the theoretical framework; the human right to health, irregular migration and citizenship, new-nationalism, and the emergence of discursive (human rights) politics.

Chapter 3: Case Analysis of Irregular Migrants' Uneven Access to Healthcare After Royal Decree Law 16/2012

I have divided the case analysis into four parts: context and historical background of RDL 16/2012, political opportunity structures, contentious performances by autonomous communities and, lastly, the formation of collective actors.

3.1 Context and Historical Background of RDL 16/2012

In the last two decades of the 20th century, after Spain's dictator Franco died in the 70's and the country underwent a process of democratization, Spain gradually evolved into a welfare state (Del Pino & Pavolini, 2015, p.247). This process was accompanied by, among other things, the adoption of certain laws relating to entitlements to education, healthcare and social welfare protection. Back in 1986, through the *Ley General de Sanidad*, Spain created the Spanish National Health System or SNHS (Cimas et al, 2016, p.385). Healthcare became funded through general taxation and healthcare coverage expanded incrementally to all those residing in Spain, specifically through laws enacted in 1989, 2000 and 2011 (Vázquez & Terraza-Núñez, p. 239; Cimas et al, 2016, p.385). Especially the law passed in 2000 (Ley 4/2000) proved decisive for migrants in an irregular situation as they were granted, regardless of their precarious legal status, the same healthcare and education entitlements as Spaniards, under the condition that they were registered at a municipal level (Cimas et al, 2016, p. 385). This meant that by 2011, a system of (free) universal coverage existed.

This progressive realization of health rights over the last decades ended in April 2012 as a consequence of a Royal Decree Law ('RDL 16/2012') enacted by the PP government in the context of the supposed need of austerity measures in the economic crisis that hit Spain in 2008 (Fuentes, 2015). According to the new government led by the Partido Popular, the healthcare system needed to be fundamentally altered in order to '*guarantee the sustainability of the National Health System*' (Gallo & Gené-Badia, 2013, p.2). Defending its legislation, the Partido Popular argued for the need to end 'health tourism', despite the fact that this represented a different issue than the 'problem' of including irregular migrants in the system, rhetorically it proved important (Fuentes, 2015). The Royal Decree-Law was introduced at a time when the healthcare sector was already undergoing significant budget cuts at a regional level following the alleged need to cut government spending (cuts of around 5% in 2012 in comparison to 2010) (Gallo & Gené-Badia, 2013, p.2). Despite the significant impact RDL 16/2012 would have on the healthcare system, which will be illustrated shortly, RDL 16/2012 did not entail nor require a consultation processes with relevant stakeholders such as healthcare professionals and civil society organisations (Advocacy Officer MDM, personal communication, 23 May, 2018; Gallo & Gené-Badia, 2013).

By enacting RDL 16/2012, the PP government introduced a healthcare system that moved away from universality toward a system in which some were stripped away from their access to healthcare, whereas others would remain entitled to receive healthcare, namely Spaniards in employment and their beneficiaries (e.g. children under 26) (Heras-Mosteiro, Sanz-Barbero, & Otero-Garcia, 2016, p.283). Irregular migrants constituted a significant group that lost its access to healthcare; around 150,000 of the 873,000 non-residents that lost their access to primary healthcare were irregular migrants (Fuentes, 2015, p.289; Heras-Mosteiro et al., 2016, p.283). Through the RDL healthcare coverage became dependent on social security entitlement (Cimas et al., 2016, p.385). From this point onwards, irregular migrants were solely entitled to receive emergency healthcare, with the exception of minors under 18 and pregnant women (Fuentes, 2015). Besides excluding irregular migrants from primary care, RDL also revoked certain previously free services or products for Spaniards; it established a system in which people had to co-pay for medication (Heras-Mosteiro et al., 2016, p.284). Curiously, whereas healthcare provision is paid through general taxes, meaning

irregular migrants actually contribute to the system through consumption, they are not entitled to reap the benefits of it (Gallo & Gené-Badia, 2013, p.3).

Unsurprisingly, civil society and health professionals criticised the enactment of RDL 16/2012, not only because people lost the right to health whereas Spain has ratified the ICESCR including the Optional Protocol, but also because the promised savings could not be scientifically underpinned or proven (Fuentes, 2015). In contrast, evidence shows that providing primary care to irregular migrants is less expensive than excluding them from it and forcing them to ultimately make use of emergency care (a more costly type of care) (European Union Agency for Fundamental Rights, 2015). Not long after RDL got implemented, a campaign was set up by health professionals (e.g. 'Yo sí, sanidad universal' and SemFYC, the Spanish Society of Family and Community Medicine) who called upon others to 'conscientiously object' to RDL 16/2012 in the name of their Hippocratic oath (Gallo & Gené-Badia, 2013, p.4). The campaign entailed the provision of information on how to become a conscientious objector and what its consequences could be for health professionals legally speaking; the campaign team encompassed legal advisors who could assist health professionals attending irregular migrants from facing legal issues (García Ruiz, 2016, p.1088).

The response by civil society actors subsequently led to a government proposal to allow irregular migrants to privately cover themselves, which came into effect from October 2012 onwards, but since the costs ranged from 710 to 1864 (65+) euro per month depending on the irregular migrant's age, it proved inaccessible to most (Gallo & Gené-Badia, 2013, p.4; Fuentes, 2015, p.284). Over the years, an advocacy platform, which also documented violations of the right to health, was set up to unify CSOs efforts against RDL 16/2012, entitled 'REDER', which was/is coordinated by *Medicos del Mundo* (Advocacy Officer MDM, personal communication, 23 May, 2018).

A qualitative study conducted in 2016 confirmed the critique among health professionals (Heras-Mosteiro et al., 2016, p.283). Apart from the critical response by civil society organisations, lower levels of government were also not keen on implementing the law (Fuentes, 2015). Many autonomous communities openly rebelled against the state by not implementing the law or by devising ways to circumvent the 'harsh' edges of it (Cimas et al., 2016). Only few autonomous communities implemented RDL 16/2012 fully (e.g. Castilla-La Mancha in the period 2012-2015) (Fuentes, 2015, p.292; Cimas et al., 2016, p.389). Importantly, regional elections in 2015 led to the victory of parties opposing RDL 16/2012 in many autonomous communities, which led to even more regional governments to draft laws and norms defying RDL 16/2012. The response by regional governments will be elaborated upon in the section on contentious performances. Notably, while conducting my research project, the new socialist government of Spain announced on the 15th of June that it would restore the previous health system based on universality, which will grant irregular migrants access to healthcare services (Angel Sanz, 2018). CSOs will be involved in the process of drafting and monitoring the new health policy bringing back universality to the healthcare system ("La Plataforma REDER," 2018).

3.2 The Institutional and Political Setting; Political Opportunity Structures

In relation to analysing political opportunity structures, a critique has been the use of diverse variables among scholars (Giugni, 2009, p.363). Although I have decided to look into the six variables identified in the theoretical framework, the scope of my thesis does not allow me to touch upon all political opportunity structures in depth. Moreover, I do not pretend to do justice to the complexity of the many variables that could be looked into in relation to political opportunity structures. Despite of this, I believe it to be important to analyse and use the concept as to highlight how the

Spanish institutional and political context influenced the successfulness of social and political mobilization against RDL 16/2012.

A key political opportunity structure in the context of healthcare is the *'multiplicity of independent centers of power within the regime'* (McAdam et al., 2009, p. 263). The regime being the Spanish state, this dimension is important given that many competencies have been devolved to regional governments over the years, among which health and education. Whereas some autonomous communities were given the competency of health in the 80's, others were granted responsibilities in the 2000s (Del Pino & Pavolini, 2015, p.248). The extent of decentralization goes so far that one can identify *'elements of both dual and cooperative federal systems'* in Spain (Del Pino & Pavolini, 2015, p.248). Certain competencies are allocated between state and regional governments, although most competencies are shared in one way or another, which results in a continuous process of contestation on competencies, e.g. in the area of health.

Interestingly, after the economic crisis struck Spain this gradual movement toward decentralization has been increasingly contested. Following the economic crisis in Spain, the power of autonomous communities weakened in favor of the central state who was given a *'political opportunity window'* to intervene in regional competencies in the name of austerity measures, as well as in the context of corruption scandals on regional levels (Del Pino & Pavolini, 2015, p.253). The loss of power of the autonomous communities can additionally be explained by the fact that the central government expenditure rose, whereas the expenditure of autonomous communities decreased, thus effectively altering the power positions in favour of the central government. The contestation on competencies is especially evident in recent years where the state government has tried to intervene in the competencies of regional governments through appealing certain decisions in front of the constitutional court of Spain. It is important to acknowledge the role the constitutional court plays in settling disputes between the central governments and the *'rebelling'* autonomous communities (Del Pino & Pavolini, 2015). In the context of health, the Spanish PP government has put several cases in front of the constitutional court. Some of the more recent judgments have been in favour of state intervention, effectively weakening the power position of the regional governments (Legal Advisor Health Ministry Navarra, personal communication, June 1, 2018; Advocacy Officer MDM, personal communication, 23 May, 2018).

Since the healthcare system is decentralized, one can speak of a multiplicity of independent centers of power in the context of health. Although the autonomous communities have certain competencies independent from the state, they do also have to remain within certain conditions set by the nation state (Legal Advisor Health Ministry Navarra, personal communication, June 1, 2018). In the words of a the health director of Cantabria:

'The autonomous community has exclusive health competencies. That is to say, health competencies have been transferred away from the national government, although it reserves certain situations of setting strategies, limits, and regulations. The [regional health] ministries [...] also have the mission of, in relation to the [national] government, claiming certain competences, to protest certain intrusions in their competencies or to negotiate those limits that the State reserves to unify a little the national health system. [...] However, the right to health care, which is a right that is set by legislation, is the norm of the State. The autonomous community can make some changes within its powers but has to abide by the general rule' (Health Director Cantabria, personal communication, May 30, 2018).

In other words, their relative autonomy gives them freedom to defy national legislation and enables them to challenge rules that they find to be not in their interest, something which will be elaborated upon in the section about contentious performances (Health Director Cantabria, personal

communication, May 30, 2018; Legal Advisor Health Ministry Navarra, personal communication, June 1, 2018). Importantly, *'[...] all Autonomous Communities enjoy the same degree of political autonomy and the differences between the exercise of their powers is rather low [...]. The only exception is the specific financial system of the Basque Country and Navarra'* ("Division of Powers," 2012). The latter is important to take into account as it may give these regions slightly more power to challenge national legislation, given that they levy and collect their own taxes and can argue to be fiscally independent from Spain. However, given the above, overall, the extent of autonomy enjoyed by the 17 different ACs is comparable.

The 'openness' of the Spanish state is shaped by the extent to which it is decentralized territorially and functionally; the more decentralized a state, the lower the capacity of individual actors and the more difficult it is for any one actor to act unilaterally (Kriesi, 2004, p.70). Moreover, *'[...] decentralization implies a multiplication of state actors, and, therefore, of points of access and decision-making'* (Kriesi, 2004, p.70). These multiple points of access function as a political opportunity structure for mobilizing actors against RDL 16/2012 as it simply widens their possibilities to influence decision making and weakens the power of the central government to implement RDL 16/2012 effectively. This has been illustrated by the advocacy officer of Medicos del Mundo: *'once we saw that at a national level there was a huge difficulty in convincing the government to move backwards and to change what they had done, we tried to articulate at a regional level alternatives [...] working with regional governments and advocating at regional governments to ask them to change the regional norms'* (Advocacy Officer MDM, personal communication, 23 May, 2018). In other words, in their pursuit to combat [the effects of] RDL 16/2012, the institutional makeup of the Spanish state allowed the mobilizing actors to navigate the various points of access into the decision-making process.

It can be derived from the literature that the relative 'instability' of political arrangements represents another political opportunity structure. During the elections in 2011, the Partido Popular gained an absolute majority (the second biggest in Spanish democratic history) (Martín & Urquizu-Sancho, 2012). This generated a situation in which opposition parties lacked the political 'power' to effectively challenge RDL 16/2012, as they were restricted in passing alternative legislation through parliament. In other words, a situation of relative political stability existed. In the general elections of 2015 and 2016 respectively, the Partido Popular lost its absolute majority, although it remained in power (Simón, 2016). This limited the government's capacity to act and increased the access points for social movement actors to influence decision-making. In the end, the lack of an absolute majority, and therefore the relative instability of the government, allowed the opposition party PSOE to take over power in government in light of corruption scandals among PP politicians through a vote of no confidence by opposition parties (Minder, 2018). Subsequently, two weeks after the new (socialist) government was installed they announced they would implement legislation to return to a universal healthcare system, meaning that irregular migrants will once again regain access to healthcare (Angel Sanz, 2018).

Moreover, in relation to political alignments and the access for mobilizing actors to influence the decision-making process, the level of democratization and the electoral system are of importance. It is relevant to look into the level of democratization as this may tell us something about the state's willingness to engage and listen to other (new) actors. The level of democratization also reflects the number of access points social movement actors have at their disposal to influence the decision making process (Kriesi, 2004). According to the Economist Intelligence Unit's Democracy Index, Spain constituted a full democracy throughout the years following 2012 ("The Economist Intelligence Unit's Democracy Index," 2018). The fact that the Spanish electoral system is based on proportional representation means mobilizing actors have more points of access to influence decision-making, since, in contrast to majoritarian or plurality electoral systems, proportionality means actors can

more easily access the political arena (Kriesi, 2004, p.70). Likewise, *'the more proportional an electoral system, the greater usually the number of parties, which again increases the possibilities of access'* (Kriesi, 2004, p.70). This point is illustrated by the advocacy officer of Medicos del Mundo:

'So even if we were approaching the socialist party in, let's say, Valencia, we were also approaching the socialist party in Madrid at a national level, so it was both ways. In this sense, we reached an important outcome in 2015 right before the general elections, in March 2015. We reached an agreement with all the political parties from the opposition, so except Partido Popular and Ciudadanes, [...] in which they all committed that should they govern at any regional level after the elections they would pass laws to provide for universality. And in fact, that was fulfilled' (Advocacy Officer MDM, personal communication, 23 May, 2018)

Similarly, on a regional level the 'instability' of political arrangements is also of importance. For example, in 2012 the UPN in Navarra designed a social program to assist those who were excluded from receiving healthcare after RDL 16/2012, but *'especially the political opposition of Navarra, considered it was not enough... given that it was a type of social welfare assistance, as opposed to an intention that every citizen should have the right to health'* (Legal Advisor Health Ministry Navarra, personal communication, June 1, 2018). The moment the opposition in Navarra achieved a parliamentary majority they proposed Statutory Law 8 / 2013, with which they brought back the universal right to healthcare to any resident of Navarra, irrespective of a precarious legal status (Legal Advisor Health Ministry Navarra, personal communication, June 1, 2018). The loss of a parliamentary majority of the center right party thus led to the adoption of the most inclusive law in all of Spain, despite the fact that the center right UPN kept in power until 2015.

In terms of the availability of influential allies or supporters for challengers, the notion of *'nested political opportunity structures'* (Smith, 2004, p.317) is of significance as it sheds light on the complexity of available actors to influence decision-making. Since the Spanish state has made agreements internationally with other states and international bodies, these agreements can be used to hold the Spanish government accountable. Examples include signed human rights treaties. At this juncture, it can be stated that *'local political opportunity structures are embedded in national political opportunity structures, which are in turn embedded in international political opportunity structures'* (Rothman & Oliver, 1999, p.43). The latter creates *'possibilities for complex patterns of relations among actors seeking political influence'* (Smith, 2004, p.317). As the analysis of legislative and administrative documents will show, influential allies or supporters for challengers include the World Health Organization, el Defensor del Pueblo (Ombudsperson), as well as human rights instruments, such as International treaties and UN bodies. In the concluding observations of the Committee on Economic, Social and Cultural Rights, Spain was urged to adopt the necessary policies and laws to grant access to healthcare to irregular migrants, in line with article 2 and 12 of the ICESCR (Committee on Economic, Social and Cultural Rights, 2018).

Moreover, apart from the above allies, and in line with proportional representation, a significant number of political parties existed (in the opposition) that turned its back against RDL 16/2012 from the very beginning, with the exception of Ciudadanos. The existence of these parties and actors has been important for civil society organizations to mobilize against RDL 16/2012, e.g. with reference to the agreement made in 2015 just before the regional elections (Advocacy Officer MDM, personal communication, 23 May, 2018).

Given Spain's level of democracy and in light of the extent to which the regime represses or facilitates collective claim making, it can be concluded that in the area of health, state repression does not occur in the explicit, violent sense. The state government obstructs collective claims making in other ways, e.g. through constitutional appeals by challenging regional laws (e.g. in Catalunya,

Valencia, Navarra, Pais Vasco, Cantabria etc.) (Advocacy Officer MDM, personal communication, 23 May, 2018). By constitutionally challenging the regional governments, turning a political question into a legal one, the central government has used its powers to limit collective claim making,

Importantly, certain constitutional rights the central government enjoys have obstructed the process of claims making by opposition parties and CSOs. Despite the fact that a window of opportunity established itself after the general elections of 2016, when the opposition parties reached a parliamentary majority and alternatives could be proposed in the parliament, RDL 16/2012 was not reformed. The possibility of the government to veto parliamentary initiatives, regardless of their own minority position, led to a situation where any parliamentary initiative regarding healthcare for irregular migrants was blocked. Despite the constitutional court ruling that the PP government was abusing its right to veto parliamentary initiatives, the PP government continued to do so (Advocacy Officer MDM, personal communication, 23 May, 2018).

Moreover, apart from this, and looking at the legislation at hand, the legislative instrument of a Royal Decree-Law allows a government to pass legislation without consultation with other actors, since *'royal decrees are considered and used as government emergency pieces of legislation that requires on no previous parliamentary nor consensus with other parties'* (Gallo & Gené-Badia, 2013, p.2). The existence of this form of legislation in the Spanish constitution - enshrined in article 86.1 - in itself somewhat restricts the process of collective claim making, although it can only be used if an urgent and an extraordinary need can be proven (Beukers, de Witte, & Kilpatrick, 2017, p.205).

Lastly, *in light of the changes in institutional factors*, as was touched upon before, it can be stated that the elections - both nationally and regionally - have proven fundamental in the facilitation of collective claims making against RDL 16/2012. After the regional defeat of the PP, many parties opposing RDL 16/2012 came to power, which were subsequently able to more publicly denounce the national legislation than the PP regional governments [not bound to party loyalty]. Moreover, in light with institutional changes, key to challenging RDL 16/2012, as the qualitative analysis will show in the next section, was the presence of preceding legislation that had a universal character. This therefore constituted a political opportunity structure; related to the notion of path dependency, these preceding laws and agreements provided the regional governments and CSOs with the ability to (legally) challenge RDL 16/2012.

Overall, political opportunity structures as well as a lack of opportunity structures can be identified, both of which have influenced the political and social mobilization against RDL 16/2012. In certain ways, there has been a lack of political opportunity structures from the perspective of CSOs and regional governments. After the crisis hit Spain in 2008, the power of autonomous communities weakened in favor of the central state that was able to intervene in regional competencies in the name of austerity measures and in the context of corruption scandals on regional levels. Moreover, certain constitutional competencies of the government in the context of the economic crises, such as the unilateral enactment of legislation in the form of RDLs and the veto power have restricted successful claims making against RDL 16/2012.

On the other side, important factors shaping success of social mobilization were the multiplicity of independent centers of power and the 'openness' of the regime, a result of Spain's decentralised competencies in health and the democratic nature of the Spanish state. The decentralized nature of the Spanish state and the presence of influential allies among opposition parties and at a national and international level reduced the central governments' capacity to act unilaterally in implementing RDL 16/2012 and allowed CSOs to navigate the various points of access into the decision-making process to challenge RDL 16/2012. The 'instability' of political arrangements in relation to an electoral system based on proportionality, which allowed for institutional and political shifts to take

place (at different levels), furthermore positively impacted the success of social and political mobilization against RDL 16/2012. The instability of political arrangements at regional levels (e.g. Navarra) and at the national level following the loss of PP's absolute majority in 2015/2016, constituted a crucial political opportunity structure, e.g. in relation to the adoption of more inclusive regional norms. All the above-mentioned political opportunity structures have contributed to (the differentiation and) the realization of the human right to health within Spain. Ultimately, a change in government, a consequence of a vote of no confidence over a corruption scandal within the PP, led to the withdrawal of RDL 16/2012 [announced in June 2018].

3.3 Contentious Performances by Autonomous Communities

In relation to contentious performances against RDL 16/2012, I will limit myself to those formalized into laws and norms, and analyse the claims that have been put to the fore by different regional governments. In relation to defying RDL 16/2012, autonomous governments have developed instructions, norms, directives and laws so as to extend healthcare provision to irregular migrants. In these legislative and governmental documents certain claims can be identified, arguments in favour of extending healthcare coverage to irregular migrants and against RDL 16/2012. After qualitatively analysing the legislative & administrative documents, I have summarised the main arguments defying RDL 16/12 in the tables below. I have ordered them according to the political party in power and the governmental term, effectively creating four different tables. In addition, I have created a table depicting the abbreviation and full name of the political parties and their political colour (See table 5).

Table 1. Overview of Main Claims to Extend Healthcare Provision by Regional PP Governments (2012-2015)

| Autonomous community | Political Party 2012-2015 (2016) | Health Inclusiveness | Arguments to extend healthcare beyond RDL |
|--------------------------|----------------------------------|----------------------|---|
| Cantabria | PP | Moderate | <ul style="list-style-type: none"> • Maintain and improve the level of collective health • Reduce the risk of disease transmission • Avoid the deterioration of health problems in patients • Preventative healthcare is more effective, cheaper and more efficient than emergency care |
| Valencia | PP | Moderate | <ul style="list-style-type: none"> • Health promotion • Prevention of diseases and provision of healthcare • Prevention and treatment of reportable diseases, infectious diseases and mental illnesses |
| Galicia | PP (until 2016) | Moderate | <ul style="list-style-type: none"> • Maintain and improve the level of collective health • Reduce the risk of disease transmission • Avoid the deterioration of health problems in patients • Preventative healthcare is more effective, cheaper and more efficient than emergency care • Context of current globalization |
| Aragon | PP | Moderate | <ul style="list-style-type: none"> • Maintain and improve the level of collective health • Reduce the risk of disease transmission • Avoid the deterioration of health problems in patients • Practical reality ('we cannot ignore') • Reportable diseases laid down in EU Regulations |
| Extremadura | PP | Moderate | <ul style="list-style-type: none"> • RDL 16/2012 discourages seeking medical assistance which can effect the health of the population • To protect public health • Reduce the risk of disease transmission • Avoid the deterioration of health problems in patients |
| Madrid | PP | Low | <ul style="list-style-type: none"> • Public health |
| Balearic Islands | PP | Low | <ul style="list-style-type: none"> • Public Health |
| Murcia | PP | Low | <ul style="list-style-type: none"> • Effectiveness of RDL 16/2012 • Emergency care is understood as an integral and continuous care • To preserve the health not only of the patient but also of the community |
| Castile-La Mancha | PP | N/A | N/A |
| La Rioja | PP | N/A | N/A |
| Castilla y León | PP | N/A | N/A |

Source: Own Elaboration based on qualitative analysis of governmental documents. Health inclusiveness derived from Cimas et al., (2016).

Table 2. Overview of Main Claims to Extend Healthcare Provision by non-PP Regional Governments (2012-2015)

| Autonomous community | Political Party | Health Inclusiveness | Arguments to extend healthcare beyond RDL |
|----------------------|-------------------------|----------------------|---|
| Navarra | UPN | High | <ul style="list-style-type: none"> • Right to (free and universal) healthcare • Principle of universality • Legal insecurity created by RDL 16/2012 • Breach of Autonomous Community Competencies; competent to independently develop health policies • Preceding regional laws in favour of free and universal healthcare • The will of the Parliament of Navarre |
| Andalucía | PSOE | High | <ul style="list-style-type: none"> • Constitutional Right to Health (Art. 43) • Principle of universality • Principle of equality • Collaboration agreement with Civil Society Organisations • Breach of Autonomous Statute of Andalucía recognizing right to universal health • Preceding regional laws in favour of universality and equality • Principle of efficiency (homogenize) |
| Asturias | PSOE | High | <ul style="list-style-type: none"> • The Constitutional Right to Health (Art. 43 and Art. 10) • Promotion of health and Prevention of disease • Principle of equality • Principle of universality • Protection of Public and Individual Health • Preceding Laws (Ley 33/2011 and Ley 14/1986) • Human Dignity • The UN Declaration of Human Rights • International Treaties ratified by Spain • European Charter of Fundamental Rights (art. 35) |
| Catalunya | CIU with support of ERC | Moderate | <ul style="list-style-type: none"> • Resolution of the Ombudsman (June 20, 2012) • European Charter of Fundamental Rights (art. 35) • European Convention on Human Rights • Declaration of Alma-Ata (1978) • Resolution of the European Parliament of 8 March 2011 • General Comment No. 14 of CESCR • Article 12 of the ICESCR (Inc. Optional Protocol) • Constitution of the World Health Organization • Avoid the deterioration of health problems in patients • Avoid liability on behalf of Spain of breaching treaties • Principle of proportionality; economic savings vs. damages • Protect Public health • Necessary condition for the effective realization of the other rights • Competencies Catalan Health Service |
| Euskadi | PSE-EE with PP support | Moderate | <ul style="list-style-type: none"> • The Constitutional Right to Health (Art 43) • Preceding laws that established universality • Principle of Universality • Principle of Equality • Principle of effectiveness • The economic crisis is the least opportune moment to restrict healthcare coverage • Autonomous Statute (Art. 9 and 18) • Competent to establish own policies to protect health • Guarantee of financial sufficiency and budgetary stability |
| Canarias | CC | Moderate | <ul style="list-style-type: none"> • Promotion of health and prevention of diseases • Principle of effectiveness • Practical reality in era of globalization • Competent to design own policies to protect health (Ley 11/1994, Art. 42, 43) • The right of vulnerable groups (e.g. those with chronic and invalidating diseases) to special and preferential health policies (Ley 11/1994, Art. 9) |

Source: Own Elaboration based on qualitative analysis of governmental documents. Health inclusiveness derived from Cimas et al., (2016).

Table 3. Overview of Main Claims to Extend Healthcare Provision by non-PP Regional Governments (2015 -2018)

| Autonomous community | Political Party 2015 - 2018 | Estimation Health Inclusiveness | Arguments to extend healthcare beyond RDL |
|---------------------------|--|---------------------------------|--|
| Extremadura | PSOE | High | <ul style="list-style-type: none"> • Constitutional right to health (Art. 43) • Principle of universality • Protect public health through preventive measures • Combat social exclusion • Preceding national and regional laws establishing universality (Ley 10/2001, Ley 16/2003, Decreto 31/2004 & Ley 33/2011) • Principles of social justice and equality • Human dignity • Avoid the deterioration of health problems in patients • Competencies in matters of public health correspond to Autonomous Communities • Principle of effectiveness and efficiency |
| Valencia | PSPV-PSOE and Compromís with support Podemos | High | <ul style="list-style-type: none"> • Principle of universality • Universal and fundamental right to health • Avoid the deterioration of health problems in patients • Principle of equality • Constitutional right to health (Art. 43) • Preceding national and regional laws (Ley 16/2003, Ley 33/2011 & Ley 10/2014) • Competencies in matters of public health correspond to Autonomous Communities • Preserve Public Health • Human dignity • Principle of efficiency and effectiveness • Collaboration with CSO's |
| Catalunya | JxS [CiU, ERC] with support CUP | High | <ul style="list-style-type: none"> • Resolution of the Ombudsperson (June 20, 2012) • European Charter of Fundamental Rights (Art. 35) • European Convention on Human Rights • UDHR (Art. 25.1) • Declaration of Alma-Ata (1978) • Resolution of the European Parliament of 8 March 2011 • Article 12 of the ICESCR (Inc. Optional Protocol) • Urgent call of CESCR in May 2012 and General Comment No. 14 of CESCR • Constitution of the World Health Organization • Avoid the deterioration of health problems in patients • Avoid liability on behalf of Spain of breaching treaties • Principle of proportionality; economic savings vs. damages • Protect public health • Necessary condition for the effective realization of the other rights • Autonomous Statute establishing right to equal access to healthcare • Competencies Catalan Health Service • Preceding national and regional laws establishing universality (ley 14/1986 & Ley 21/2010) |
| Castilla la Mancha | PSOE with support Podemos | High | <ul style="list-style-type: none"> • Critique from civil society (e.g. associations of healthcare professionals) and the ombudsperson on RDL 16/2012 • Principle of proportionality and suitability; other less burdensome alternative policies could have been drafted to cut healthcare costs • Protect public health • Exclusive competencies established in Autonomous Statute of social assistance and social services • Principle of equality • Principle of universality |
| Cantabria | PRC and PSC-PSOE | High | <ul style="list-style-type: none"> • Constitutional right to health (Art. 43) • Preceding national and regional laws (Ley 14/1986 & Ley de Cantabria 7/2002) • Competency to develop health policies lies at the level of ACs • Intensify and reinforce the principle of universality • Right of health as right of citizenship • Protect public health • Principle of effectiveness and efficiency • Principle of equality |
| Baleares | PSOE and Més per | High | <ul style="list-style-type: none"> • Constitutional right to health (Art. 43) • Preceding national and regional laws (Ley 14/1986 & Ley 5/2003) |

| | | | |
|-----------------|---|------|---|
| | Mallorca, with support from Podemos and Més por Menorca | | <ul style="list-style-type: none"> • Competency to develop health policies for irregular migrants without resources (Decreto 39/2006) • Autonomous Statute establishing universality (Art. 25.1) • Principle of universality • Principle of equality • Principle of efficiency and effectiveness |
| Aragon | PSOE with support from Podemos, CHA and IU | High | <ul style="list-style-type: none"> • Constitutional right to health (Art. 43) • Principle of universality • Preceding national and regional laws (Ley 14/1986/Ley 6/2002) • Autonomous Statute establishing universality (Art. 14.2) • Principle of equality • Principle of efficiency or effectiveness (homogenize) |
| Euskadi | EAJ-PNV and PSE-EE (from 2016) | High | <ul style="list-style-type: none"> • UDHR (art. 22 and 25) • European Commission guidelines • World Health Organization guidelines and advice • Constitutional right to health (Art. 43) • Preserve and protect the individual health of persons • To protect the public from public health risks • Competent to independently develop health policies, e.g. in relation to the autonomous statute (Art. 18) • Preceding regional laws establishing universality (Ley 8/1997 & Decreto 147/2015) • Principle of universality • Principle of equality and solidarity • Principle of efficiency or effectiveness |
| Canarias | CC | High | <ul style="list-style-type: none"> • Improve health of irregular migrants • Principle of effectiveness (simplify the procedure) • Reduce the risk of disease transmission |

Source: Own elaboration based on qualitative analysis of governmental documents. Health inclusiveness derived from criteria and health coverage established in laws and norms, following approach of Cimas et al. (2016).¹

Table 4. Overview of Main Claims to Extend Healthcare Provision by PP Regional Governments (2015 -2018)

| Autonomous community | Political Party 2015-2018 | Estimation Health Inclusiveness | Arguments to extent healthcare beyond RDL |
|----------------------|---------------------------|---------------------------------|--|
| Murcia | PP | High | <ul style="list-style-type: none"> • Right to health and physical integrity of the person • Protect public health • Principle of efficiency and effectiveness (e.g. to prevent a collapse of services providing emergency care) • Reduce the risk of disease transmission • Humanitarian reason and social protection |
| Madrid | PP | Low | <ul style="list-style-type: none"> • Absence of an inter-territorial standard • To avoid territorial differences between autonomous communities |
| La Rioja | PP | Low to Moderate | <ul style="list-style-type: none"> • Principle of effectiveness • To avoid territorial differences among autonomous communities |

Source: Own elaboration based on qualitative analysis of governmental documents. Health inclusiveness derived from criteria and health coverage established in laws and norms, following approach of Cimas et al. (2016).¹

¹ To estimate the health inclusiveness scores for the period following 2015, for which no scores exist, I looked at the requirements and the coverage established in the norms and laws and compared them to the requirements and coverage of the norms and laws from the preceding period and the health inclusiveness attributed to it by Cimas et al. (2016). Specifically, I compared and looked at 1) the presence of a formal definition of alternative procedures for access to healthcare, 2) the administrative requirements (number of documents and months of residency needed to qualify), 3) extent of healthcare coverage in comparison to general public 4) whether all undocumented migrants were covered or only those with limited resources. Given the scope of my thesis I could not look into all 11 variables that are looked into by Cimas et al. (2016), but since I am not interested in the meticulous score but an overall estimation of the health inclusiveness (into roughly three groups; low, medium, high), I deemed the above factors informative enough.

Table 5. Overview of (Regional) Political Parties and Political orientation

| Political Party or political alliance | Name | Party position relative to other parties | Progressive or Conservative |
|---|---|--|-----------------------------|
| PP | Partido Popular | Centre-right to right | Conservative |
| PSOE <i>In Euskadi: PSE-EE</i> <i>In Valencia: PSPV-PSOE</i> <i>In Catalunya: PSC-PSOE</i> | Partido Socialista Obrero Español | Centre-left | Relatively progressive |
| Podemos | Podemos | Left | Progressive |
| Cs | Ciudadanos | Centre | Relatively conservative |
| EAJ-PNV | Partido Nacionalista Vasco | Centre-right | Relatively Conservative |
| UPN | Unión del Pueblo Navarro | Centre-right | Relatively Conservative |
| CC | Coalición Canaria | Centre-right | Relatively conservative |
| CIU | Convergence and Union (encompasses Democratic Convergence of Catalunya) | Centre-right | Conservative |
| ERC | Esquerra Republicana de Catalunya | Centre-Left | Relatively progressive |
| Compromis | Coalició Compromís (affiliated with 'Valencian Style') | Left | Progressive |
| JxS [CiU, ERC] | Juntos por el Sí | N/A (Left and Right united) | N/A (Catalan independence) |
| CUP | Candidatura d'Unitat Popular | Left | N/A (Catalan independence) |
| PRC | Partido Regionalista de Cantabria | Centre | Progressive |
| Més | Més per Mallorca y Més per Menorca | Left | Progressive |
| CHA | Chunta Aragonesista | Left | N/A (Aragonese nationalism) |
| IU | Izquierda Unida (national affiliation with Unidos Podemos) | Left to Far left | Progressive |

Source: Own elaboration based on data from *The Manifesto Project* (Volkens et al., 2017). See Annex 2 for party positions and ideologies in plot. In relation to the few regional parties that were not included in the dataset (CUP, PRC, Més and CHA), I visited the party's website and derived their position and ideology from there.

The analysis of the legal documents affirms our understanding of lower levels of governments as initiators of claims in a process of contentious governance, as emphasised by Verhoeven and Broer (2015, p.3). The arguments and claims identified to extend healthcare beyond RDL are multifaceted. The qualitative content analysis and the tables illustrate that enacting policies in accordance with human rights does not always occur in the name of human rights laws or norms. Rather, other more practical arguments that may seem secondary to human rights advocates may be deemed most important by a regional government. Although many legislative and administrative documents contain a reference to a right to health, e.g. in relation to the constitution, the principle of universality or even human dignity, only a few explicitly relate it to international human rights treaties, namely Euskadi, Catalunya (in a very elaborate way) and Asturias (merely touches upon UDHR). At the time, different left wing and centre right parties ruled these regions, thus moving beyond political colour as the explanatory factor determining human rights references.

Intriguingly, it can be observed that, although many PP governments have extended healthcare beyond RDL 16/2012, they do not refer to a 'right' to health, with the exception of the autonomous community of Murcia (from 2015 onwards). Given the overall lower health inclusiveness (Cimas et al., 2016) among PP governments, it is not surprising that PP governments do not talk about a right to health. Looking at the documents at hand, this is reflected by the fact that many PP governments created 'social programs', which can be seen as a type of welfare assistance which one can access under certain conditions, but does not grant all people access to health.

According to the advocacy officer of Medicos del Mundo, a possible explanation for the rights language in Murcia can be found in the strong social pressure in Murcia and the overall inclusive trend observed in other communities to provide universal healthcare (Advocacy Officer MDM, personal communication, 23 May, 2018). The respective health directives of Cantabria and Navarra also confirmed the role of social pressure in contributing to more health inclusiveness in some regions, remarking that social movement action was diffused unevenly over the country (Health Director Cantabria, personal communication, May 30, 2018; Legal Advisor Health Ministry Navarra, personal communication, June 1, 2018). Another explanation could be the high number of irregular migrants in Murcia, due to the agricultural sector in which a lot of undocumented people work, and therefore the greater necessity to provide health as to reduce the risk of disease transmission (Advocacy Officer MDM, personal communication, 23 May, 2018). Although an instinctive explanation for the more inclusive healthcare policies in certain regions, no connection between the numbers of migrants vs. the inclusiveness of health policies was found in the research by Cimas et al. (2016). In all likelihood, without any conclusive answer, a combination of all these factors played a role in determining the rights language in Murcia.

The documents analysed reveal that the overall health inclusiveness improved after the elections of 2015; many autonomous communities established less rigid criteria to access healthcare, e.g. in relation to the minimum time of registration needed in the Autonomous Community (e.g. in the Canarias from 1 year to 3 months). In relation to the more inclusive trend observed after 2015, the autonomous community of Madrid passed an internal order re-introducing the provision of healthcare to irregular migrants to avoid territorial differences in the healthcare system in the context of an absence of an 'inter-territorial standard'. In the words of the advocacy officer of Medicos del Mundo: *'you could really see that it was the reaction to the fact that almost every autonomous community after 2015 started approving laws to provide universality'* (Advocacy Officer MDM, personal communication, 23 May, 2018). I would say that the standard of near universality created by other autonomous communities following 2015 functioned as a political opportunity structure; it provided social movement actors and regional governments with influential allies and functioned as support to challenge RDL 16/2012 in regions where health inclusiveness was still lower. In line with this, pressure from the regional governments to change RDL 16/2012 increased following

the 2015 elections (Advocacy Officer MDM, personal communication, 23 May, 2018; Legal Advisor Health Ministry Navarra, personal communication, June 1, 2018), something that is also reflected in table 3 by the many new norms implemented.

Whatever the arguments used, the inclusive norms adopted by PP governments depicted in table 1 affirm that the creation of inclusive health policies goes beyond the left-right dichotomy. As can be derived from the tables, many PP governments have developed more inclusive norms, although they do not use the language of human rights, nor very strong language. This could be a reflection of party loyalty on the one hand, and competing interest on the other. In the words of the health director of Cantabria:

'And their own allies of other autonomous communities surely cannot and do not want to confront their own party, but that is the double language of politics: on the one hand, I say one thing, but on the other hand I have to say something else. It [the language of inclusiveness] is a compulsory language when you are close to the citizen. When you are close to the problems, you can say that you do not see them, but they put them in front of you!' (Health Director Cantabria, personal communication, May 30, 2018).

In line with a similar argument that is often put forward as to why local levels of government are frequently more inclusive (Oomen, 2015, p.403), the last sentence of this quote demonstrates the closer gap between policymakers/politicians and the needs of people. By extension, all the interviews depicted a clear clash of interest between the state and the autonomous communities. This is also reflected in the analysis of legislative documents, e.g. from implicit sentences like: *'we cannot ignore'* to explicit references of 'globalization' and practical reality. As the legal advisor from Navarra stressed, the state and autonomous communities have different interests, among other things because they have different competencies. *'There is a total disconnection between the interests in Madrid, I mean the State, and the interests of each of the autonomous communities. In fact, none of the autonomous community is happy with this system. Everyone has made its little tricks to include them (migrants), even the ones (communities) from PP. It is not an ideological reason, as it is an interests question'* (Legal Advisor Health Ministry Navarra, personal communication, June 1, 2018).

Whereas the state has the competency over migration, he argued, the autonomous communities are responsible for healthcare provision. In line with the principle-agent problem touched upon in the theoretical framework (Fuentes, 2015), the government official in Navarra argued that these two competencies clash since RDL 16/2012 was drafted from a migration perspective as opposed to a health perspective. In other words, RDL 16/2012:

'[...] signified a policy, a punishment, from a migration perspective, to deter them [migrants] from coming, to try and make sure they go away. But the healthcare system is not for making the people leave the country; it is for providing healthcare to people who are in the country [...] the alleged purpose in Madrid was not regarding healthcare, it was another type of objective, and here in the autonomous communities we faced a healthcare issue. At that time, UPN [center-right] decided from the beginning to attend those people' (Legal Advisor Health Ministry Navarra, personal communication, June 1, 2018).

Corresponding to the autonomous communities' competencies, the argument most commonly used by regional governments is the protection of public health. This seems to be an argument that crosses left and right wing boundaries, as it is referred to in nearly all norms and laws created, irrespective of party colour, mostly in general terms by referring to the protection, promotion or preservation of 'collective' or 'public health'. Perhaps unsurprisingly, PP governments tend to more

elaborately mention the risk of disease transmission. An explicit example of the fear for disease transmission can be found in the autonomous community of Extremadura in 2013 (PP government): *'This situation could cause side effects in the [resident] population because they [irregular migrants] can contract diseases and spread them; there are many people in a regular situation who live daily with foreigners in an irregular situation, both in residential buildings, as well as in other areas'* (See Annex 1, Extremadura, Instruction of 15/07/2013). In line with the observation that norms created by PP governments tend to more elaborately mention the risk of disease transmission, CSOs like Medicos del Mundo strategically used the argument of the health risk in advocating health inclusiveness among right wing parties, as they seemed more sensitive to these arguments, in contrast to human rights (Advocacy Officer MDM, personal communication, 23 may 2018).

In addition, arguments about autonomous communities' competencies to extent healthcare coverage beyond RDL 16/2012 come to fore in nearly all norms and laws created by regional governments not ruled by the PP, which is partly a reflection of party loyalty (to not explicitly defy their own party) as well as a reflection of the decentralized nature of the Spanish state. It can be derived from the documents that in legitimizing their more inclusive provision of healthcare the regional governments refer to the existence of opposing laws agreed to in the past. These past laws of universality represent a political opportunity structure for regional governments to challenge RDL 16/2012. The laws referred to are twofold. Firstly, the universal character of preceding laws is referred to. Secondly, the autonomy in the development of healthcare policies is referred to in relation to the autonomous communities' competencies and/or autonomous statutes. Often, these are one and the same law. Based on the many arguments about competency that came to the fore through the qualitative content analysis of the legislative documents, it can be concluded that autonomous communities seem very much aware of their struggle over competency in the field of health. This is furthermore reflected by the following quote, depicting contentious politics in practice:

'By putting our legal services at work, to see what holes the national law has and what competences we can derive from our statute of autonomy and our operating laws, so that they can tell us in what the State can force us and in what we can escape [...] We put jurists to work in favor of a universal and free public service idea' (Health Director Cantabria, personal communication, May 30, 2018).

Remarkably, the qualitative analysis showed that many regional governments referred to their intervention as a 'social program'. By presenting their intervention as a social program, autonomous communities tried to claim competency in defying RDL 16/2012, without having to do so in a very confronting or explicit way such as in Navarra. Especially for PP governments this provided an opportunity to implicitly challenge the state's competency over the matter, without having to explicitly defy their own party at national level in light of competencies. The legal advisor in Navarra argued that (PP) autonomous communities are deliberately labeling the interventions 'social programs', *'because with that they are trying to derive their competence from social action, instead of health where the competencies between the autonomous community and the State is more contested'* (Legal Advisor Health Ministry Navarra, personal communication, June 1, 2018).

Nearly all parties other than the PP have interpreted the provision of healthcare as a right to everyone. Various principles underlie the provision of healthcare. Apart from the morality of human rights and or universality, the principle of equality was also often touched upon in the governmental documents. On this point, the health director from Cantabria argued: *'We understand that the health system, in addition to its health function, fulfills a role of equity and cohesion of society because it equates ... because it has nothing to do with income. It is by right, with what unifies the citizens'* (Health Director Cantabria, personal communication, May 30, 2018).

The same health director interpreted the right to health as a reflection of citizenship (also reflected in the documents analyzed), but her interpretation of citizenship differed from its connection to nationality or a formal or legal status as defined by Delanty (2000) in the theoretical framework: *'We understand as a philosophy that healthcare must be a right of citizenship: if you live here, it is a right of citizenship [...] That is why this order is created, which allows us to provide health care to all the groups residing in Spain'* (Health Director Cantabria, personal communication, May 30, 2018). Her interpretation of citizenship was thus more connected to physically residing in a place, rather than being in possession of the Spanish nationality. It corresponds to the notion of citizenship as something that can be realized substantively, irrespective of legal status.

The availability of (international) influential allies or supporters has also been reflected in the documents, for example in the ways Euskadi, Catalunya and Asturias (the latter to a lesser extent) refer to the World Health organization, the Universal Declaration of Human Rights, European norms and/or recommendations by the ombudsperson (el defensor del pueblo). Moreover, the concluding observations of the Committee on Economic, Social and Cultural Rights, as touched upon in the previous section on political opportunity structures, were referred to in Catalunya. A possible explanation for the fact that precisely Euskadi and Catalunya extensively referred to international institutions might be that, given a strong movement of autonomy in these regions, they are used to use a globalizing rhetoric to defend their autonomy; they are already aware of the (international) influential allies available to them to defy the nation-state. The latter might therefore be a reflection of path dependency. Globalizing rhetoric is a common phenomenon in the struggle for moral authority; it is a strategy to gain legitimacy from outsiders without looking self-centered (Jasper, 2008, p.276)

Several autonomous communities (Euskadi, Navarra, Valencia, Catalunya, Cantabria) have had to explicitly defend their laws providing access to irregular migrants in front of the constitutional court of Spain. On the topic, a government official in Navarra remarked: *'now they all raise together that RDL has to be removed, because it does not make sense'* (Legal Advisor Health Ministry Navarra, personal communication, June 1, 2018). The effort by the national government to turn a political issue into a legal issue has proven problematic for the autonomous communities, since *'courts are governed by law and not by the concept of rights. Then, in the end, many of these things [regional laws] fail because the royal decree is a law, like it or not, but it is a law. The courts cannot decide anything that goes against the law'* (Health Director Cantabria, personal communication, May 30, 2018). Despite negative judgments by the constitutional court declaring certain regional laws unconstitutional, regional governments have kept providing healthcare to irregular migrants, making optimal use of their legal advisors (Legal Advisor Health Ministry Navarra, personal communication, June 1, 2018).

Overall, it can be concluded that the analysis affirms the emergence of lower level human rights polities for irregular migrants, e.g. through upholding more substantive notions of citizenship and through publically defying national power hierarchies in the name of a (human) right to health, the principle of universality and human dignity, among other arguments. PP regional governments, although many of which have expanded healthcare provision to irregular migrants, do not use the 'rights' language [possibly a reflection of party loyalty], with the exception of the autonomous community of Murcia following the 2015 elections. The social pressure in this region, the general trend toward universality in many other regions, and lastly the high number of irregular migrants in this region provide a possible explanation for this exception. PP governments focus more on the risk of disease transmission, whereas regional governments not ruled by the PP more explicitly challenge the state in terms of competencies. The struggle over competencies is reflected in the documents explicitly and implicitly, e.g. explicitly with reference to claims derived from their autonomous statute or implicitly by labelling the instructions 'social programs' by which they try to circumvent the

state and claim competencies to intervene. Following the 2015 elections, more autonomous communities started to provide healthcare to irregular migrants. Although political colour is influential in the degree of healthcare provided to irregular migrants [e.g. difference between social programme and social welfare assistance or healthcare as a right], the provision of healthcare to irregular migrants and thus the defiance of RDL 16/2012 moves beyond the right-left wing dichotomy.

3.4 Formation of Collective Actors

The implementation of RDL 16/2012 led to a resistance movement at national, regional and local level. Given that the formation of collective actors is relational in nature, some mechanisms elaborated upon by McAdam et al. (2009) can be identified, such as a process of brokerage. The resistance movements encompassed various actors from different spheres; it encompassed societal, political and professional actors. In challenging RDL 16/2012, health professionals, political opposition parties and civil society organisations joined forces and created new alliances and networks. For example, *'in 2012, at different regional levels several platforms were created and the project REDER [...] is saying precisely to gather all those regional initiatives under one big umbrella at national level, and also include other organizations at a national level that are also against exclusion'* (interview, 23 May). In other words, previously unconnected groups started building alliances to collectively mobilize against RDL 16/2012.

With regard to this resistance movement, the interviews confirm that it contributed to the adoption of more inclusive health policies at a regional level (Advocacy Officer MDM, personal communication, 23 May 18; Health Director Cantabria, personal communication, 30 May, 2018; Legal Advisor Health Ministry Navarra, personal communication, June 1, 2018). This is also reflected by many legislative and authoritative documents analyzed, e.g. in the norm created by Castilla La Mancha, the critique from civil society and health professionals on RDL 16/2012 was touched upon as an argument for the inclusion of irregular migrants in healthcare (See Annex 1, Castilla la Mancha, order of 9/02/2016). Next to this, an agreement of cooperation with civil society actors was touched upon by the health ministry of Andalucía as an argument for the inclusion of irregular migrants (See Annex 1, Andalucía, Instruction of 6/6/2013).

In line with the above, the health director in Cantabria was 'absolutely convinced' social pressure constituted a major explanation as to why some PP governments adopted more inclusive health policies than their national party designed at national level:

'The social pressure ... That is, the fact that health is transferred to the autonomous community allows it to be closer to the problems of citizens, and the pressure of citizens is ultimately what moves things, even if they do not... So the autonomous community government, even if it wants to respect the national decree because it is its party that does it, is subject within the autonomous community to pressure from collectives that are demanding an answer... it has its own parliament' (Health Director Cantabria, personal communication, May 30, 2018).

The latter comment also relates the political opportunity structure of decentralization; regional governments have their own parliament, meaning politicians are not solely held accountable at national level. The presence of strong allies in parliament subsequently provides social movement actors with opportunities to advocate for more health inclusiveness. Another clear example depicting the process of brokerage is the social and political pact that was signed in September 2017 *'by all the parties of the opposition at the national level, but also by the 70 organizations and trade unions and professional organizations from the healthcare sector. They all came together and made a pact for public and universal health care system in which the parties again committed to pass a national law*

in order to overthrow the RDL' (Advocacy Officer MDM, personal communication, 23 may 2018). Although this pact constituted a major breakthrough, bringing together previously unconnected groups, the effect remained limited given that the PP government kept using its veto powers to nullify any proposal to bring back universality (Advocacy Officer MDM, personal communication, 23 may 2018).

Whereas it seems the autonomous communities did not built alliances in the formal sense of the word in response to RDL 16/2012, autonomous communities did work together, using existing and informal channels, to discuss how to respond to RDL 16/2012 and how to challenge it. Firstly, the issue was discussed multiple times in the formal inter-territorial council, the national forum in which proposals of the ministries are discussed, adopted and/or rejected by the autonomous communities (Health Director Cantabria, personal communication, May 30, 2018). However, since the national ministry also attends these meetings, and given established hierarchies and formal rules in such a forum, the autonomous communities saw themselves limited in their defiance of RDL 16/2012. In contrast, key to the formation of collective action against RDL 16/2012, were the informal channels available to the health ministries of the autonomous communities, thus circumventing the national state actors. About the period following 2012, the government official in Cantabria stated: *'There was permanent contact through phone calls and meetings. We spoke with autonomous communities on the side to ask them how they see it, what they do'* (Health Director Cantabria, personal communication, May 30, 2018). In response to the question of whether formal cooperation without the state ministry existed, the government official in Navarra responded: *'No, but there are a lot of phone calls and e-mails from health ministries [of autonomous communities] who want to include them [irregular migrants] in the National Health System, and they talk and try to create a consensus'* (Legal Advisor Health Ministry Navarra, personal communication, June 1, 2018).

According to the Health director of the government of Cantabria *'there are private forums that are not institutional but that each autonomous community establishes with the others in a private way'* (Health Director Cantabria, personal communication, May 30, 2018). This cooperation moves beyond the occasional phone call, e.g. it also encompasses meetings and the exchange of documents and strategies that may support the autonomous' claims over competencies. For example, a legal report drafted by the legal advisor in Navarra exploring the legal ways of how to continue providing healthcare to irregular migrants despite the constitutional court's negative judgment in February 2018 was shared by the health ministry in Navarra with other ministries. As a consequence of the report *'the different health ministers of the different autonomous communities started to talk about rebelling against the state'* and *'I may tell, without being pretentious, that Navarra is leading this movement'* (Legal Advisor Health Ministry Navarra, personal communication, June 1, 2018). The words in this quote - 'rebelling' and 'movement' – depict the social movement like behavior of some autonomous communities, a process that has even been observed among lower levels of governments in more centralized states such as the Netherlands (Verhoeven and Bröer, 2015).

The notions of identity shift and boundary formation come to the fore in the way the government officials during interviews talked about their own competencies and interests in relation to the state's competencies and interests, something which is also reflected in the contentious performances derived from the qualitative content analysis. *'The PP [...] that has its hidden political, economic objectives in this change, choose to create this norm. But the ones who have the problems are the autonomous communities, because a lot of people who had healthcare assistance before lost it...but they are the autonomous communities' patients!' and 'I am not affecting the whole state, I am not putting a person into the National Health System, but in my health service with my money and only to provide assistance here [in Navarra]'* (Legal Advisor Health Ministry Navarra, personal communication, June 1, 2018). In both quotes, a clear boundary is drawn between the national healthcare system and the healthcare system of Navarra. The government official clearly

appropriates the patients as being theirs, not the state's patients. By creating a boundary between Navarra – with its fiscal independency - and the State, he legitimizes their competency over healthcare and the law drafted at a regional level in response to RDL 16/2012.

According to the political advocacy officer of *Medicos del Mundo*, many to most of the laws passed in 2015 encompassed some kind of cooperation with civil society actors, e.g. through a consultation processes (Advocacy Officer MDM, personal communication, 23 may 2018). In the law drafted in Valencia, it is stated that the Health Department has worked together with civil and professional organizations to create a new reality that guarantees a dignified healthcare for every person (See Annex 1, Valencia, Law of 24/07/2015). In line with the shift from government to governance, the advocacy officer remarked: *'The regional governments really tried to get in touch with civil society, we also made ourselves present'* (Advocacy Officer MDM, personal communication, 23 may 2018). A few autonomous communities even moved beyond 'mere' consultations as some laws attributed formal roles to CSOs, e.g. monitoring the application of a regional law.

The involvement of civil society organizations at a regional level in monitoring and assessing the implementation of specific regional healthcare policies and laws is a reflection of a mechanism of co-optation. In Valencia CSOs got a formal seat at the table to assess the regional legislation drafted in 2015; a commission was set up to monitor and evaluate the application of the regional law, consisting of both governmental officials and CSO representatives (meets at least twice a year) (See Annex 1, Valencia, Law of 24/07/2015). By drawing CSOs towards the center of power in these regional governments in the context of healthcare policies, CSOs were effectively able to provide the governments with essential information on making the application of the law more effective, and thus to make the healthcare system overall more inclusive. As a consequence of the involvement of CSOs in the evaluation of the law in Valencia, an information campaign was set up to inform health providers and irregular migrants about the rights of irregular migrants (Advocacy Officer MDM, personal communication, 23 may 2018).

A similar information campaign was set up in Cantabria through the involvement of CSOs in the policymaking process following the election result and a change of government in 2015. The mechanism of co-optation proved fundamental in this autonomous community as well since the CSOs provided information to the health ministry on how to improve care and how to reach irregular migrants and inform them about their right to health (Health Director Cantabria, personal communication, May 30, 2018). Due to a process of co-optation, formally expressed through the creation of a commission and follow-up commission, the idea arose to create an information sheet indicating irregular migrants' right to healthcare in the different languages, such as Arabic (See Annex 3). Importantly, the role of civil society goes beyond the provision of information; in some cases they also acted as intermediaries at healthcare centers, assisting irregular migrants in going to healthcare centers and translating things for those who did not speak Spanish (Health Director Cantabria, personal communication, May 30, 2018; Advocacy Officer MDM, personal communication, 23 may 2018). A very explicit example of co-optation can be found in the autonomous community of La Rioja, where following the elections in 2015, access of irregular migrants to healthcare was channeled through Cruz Roja and Caritas, who signed a special agreement for this arrangement with the ministry of health of La Rioja (See Annex 1, La Rioja, announcement of 8/10/2015).

In relation to the diffusion of social movement action against RDL 16/2012, the strength of the social movement actors differed strongly per region, partly reflecting the different legislative context and health inclusiveness in each region. A challenge in mobilizing social movement actors following 2015 was the normalization of the situation and the adoption of more inclusive regional norms, lowering local social movement actors' priority in challenging RDL 16/2012. For example, despite RDL 16/2012 being a national issue affecting all regions to some degree, in Navarra and Andalusia civil society did

not strongly advocate against RDL 16/2012 because in those regions the regional governments had designed ways to include irregular migrants which prevented CSOs from adopting it as a major issue (Advocacy Officer MDM, personal communication, 23 may 2018; Legal Advisor Health Ministry Navarra, personal communication, 1 June, 2018). This fragmentation of social movement action, although partly resolved by a process of brokerage and the creation of new alliances and networks of previously unconnected groups, may have negatively impacted the fight against RDL 16/2012 at the national level. In line with this, the health director in Cantabria characterized the social movement against RDL 16/2012 as *'not active enough'*; whereas the response of co-payments was fierce, the response of the stripping away of the rights of irregular migrants was less fierce because it did not affect the entire population, nor people in a similar way (given inter-territorial differences in health inclusiveness) (Health Director Cantabria, personal communication, May 30, 2018).

Apart from inter-territorial differences fragmenting social movement actors, the advocacy officer of Medicos del Mundo also identified a process of demobilization in the years following 2012. Some organizations that were part of REDER had lost their strength once they were already advocating against RDL 16/2012 for years. *'[...] they were very active for a few years but it is very exhausting to maintain a high level of social conflict when you don't achieve change at the same time, so demobilization comes at a consequence'* (Advocacy Officer MDM, personal communication, 23 may 2018). The new norms implemented in 2015 also facilitated this process of demobilization, since overall health inclusiveness increased in many regions, despite it being less than before RDL 16/2012. Although civil society action slightly lessened, contention between regional governments and the national government increased given the changing political landscape and the presence of more inclusive norms in autonomous communities.

All in all, various mechanisms of contentious governance can be identified in relation to irregular migrants' access to healthcare and the formation of collective action. Inter-territorial differences in health inclusiveness meant that social movement action against RDL 16/2012 was highly uneven. To overcome this fragmentation, a critical mechanism in the formation of collective action against RDL 16/2012 proved to be the process of brokerage, in which societal, political and professional actors joined forces by creating novel alliances. Moreover, key to the formation of collective action from the regional governments' perspective were the informal channels available to the health ministries of the autonomous communities, thus circumventing the national state actors. Especially after 2015, a process of co-optation and the involvement of CSOs in the policymaking process resulted in the improvement of the application of local norms and laws, and overall health inclusiveness. A challenge in mobilizing social movement actors following 2015 from the perspective of CSOs was the normalization of the situation and the adoption of more inclusive regional norms lowering local social movement actors' priority in challenging RDL 16/2012 nationally. However, increased contention between autonomous communities and the state, and overall higher inclusiveness at a regional level, slightly substituted for this demobilization.

Conclusion

Irregular migrants, a vulnerable group of people in our respective societies, are often faced with a lack of human rights protection, among other rights, expressed by the inaccessibility of the human right to health. The xenophobic character that defines the presence of a new kind of nationalism in Europe has aggravated the realization of human rights for irregular migrants at national levels. The strong linkages between citizenship, nationalism and human rights protection have resulted in pressure and critique on the principle of universality; those without appropriate citizenship risk being stripped away of their rights by nationalist forces. The implementation of RDL 16/2012, which stripped away the health rights for irregular migrants in Spain, is a reflection of the latter development in the context of the economic crisis. In contrast to this development, the case analysis has shown that the relative gap or void of human rights protection left behind by new nationalism is being filled in by other political entities, among which regional governments.

The implementation of the human right to health in Spain has been highly uneven. Following the enactment of RDL 16/2012, regional governments, even those ruled by a similar party as the national level, rebelled against the state's decision and designed, through a process of contentious governance and in defiance of national legislation, inclusive health policies. A contrary, more inclusive development than new-nationalism can therefore be identified, in line with the shift away from 'government' to governance, namely the emergence of 'human rights polities', a novel concept defined as local, regional or supranational political entities (less subject to new nationalism) that develop policies, contrary to the state's wishes, to protect human rights (e.g. include irregular migrants). The emergence of human rights polities goes beyond the development and emergence of human rights cities, given the latter's exclusive focus on the local level and the fact that contention does not presupscribe it. Importantly, the concept addresses the gap in academic literature in which the regional level has too often been overlooked, or thrown on one heap with local governments, despite distinct and competing competencies and characteristics between them.

Whereas some scholars like Cimas et al. (2016) identified the influence of political color in determining the implementation gap of RDL 16/2012, on itself it did not explain the divergence between autonomous communities and the national government, nor did it solely explain the differing health inclusiveness among the regions. In other words, other factors also played a role, but which were these factors and to what extent did they play a role? Although my research has not been able to identify a clear-cut answer to this question, it has nonetheless shed light on the factors that contributed to the implementation gap, e.g. with reference to the different interests based on the conflicting competencies of migration versus health (a reflection of the principle-agent problem), fragmented social pressure across the country, and the different political opportunity structures between the regions and the central government (e.g. in terms of stability of political alignments at regional/national government).

Overall, political opportunity structures as well as a lack of opportunity structures have been of importance in the political and social mobilization against RDL 16/2012. The crisis that hit Spain in 2008 weakened the power of autonomous communities in favor of the central state, making it more difficult to challenge RDL 16/2012. Moreover, certain constitutional competencies of the central government in the context of the economic crises, such as the unilateral enactment of legislation in the form of RDLs and the veto power restricted the potential of ACs and CSOs to challenge RDL 16/2012.

In contrast, the multiplicity of independent centers of power, the presence of influential allies, and the 'openness' of the regime, a result of Spain's decentralised competencies in health and the democratic nature of the Spanish state, have proven to be critical in realizing the human right to

health at a regional level, as it reduced the central governments' capacity to act unilaterally in implementing RDL 16/2012 and allowed CSOs to navigate the various points of access into the decision-making process. The elections in combination with the instability of political arrangements at national (following 2015) level contributed to the higher health inclusiveness observed following 2015.

Inter-territorial differences in health inclusiveness meant that social movement action against RDL 16/2012 was diffused unevenly over the country. Novel alliances were created through a process of brokerage, a mechanism that proved vital in overcoming social movement fragmentation and demobilization. In line with the notion of governance, informal channels available to the health ministries of the autonomous communities enabled regional political entities to circumvent the national state. The overall improvement in health inclusiveness following 2015 can be partly attributed to this, as well as to a process of co-optation of CSOs in the policymaking and evaluation process of regional norms and laws.

The analysis has shown that regional governments, faced with the practical realities of social, economic and political exclusion of a considerable group of its residents and different competencies than the national state, have rebelled against the state through contentious performances in favor of more inclusive policies, albeit not always in the name of human rights. As the analysis demonstrated, PP governments, arguably faced with party loyalty, focused more on the risk of disease transmission and generally extended the access to health through social programs, whereas regional governments not ruled by the PP more explicitly challenged the state in terms of competencies and extended the access to health through acknowledgement of the (human) right to health. The latter distinction emphasizes the importance for human rights advocates to not merely focus on human rights in persuading (especially right wing) governments in adopting human rights standards; other arguments such as public health, infringement of competencies, practical reality, efficiency, costs and inter-territorial standards may be deemed more important and thus persuasive to these governmental entities.

All in all, the analysis of the political opportunity structures, the contentious performances and the formation of collective actors reflect the emergence of human rights polities in some autonomous communities [in the context of health], namely the ones that adopted the rights language and consciously challenged the national law in the name of the (human) right to health and the principle of universality. Nonetheless, even in the autonomous communities that did not adopt a (human) rights language, healthcare provision has been extended beyond RDL 16/2012. In light of the realization of human rights, this means that regional political entities prove more inclusive than the national political entity subject to new nationalism.

In our efforts to realize human rights on the ground, there is a need to better take into account the distinct competencies of different levels of government. In line with the argument of Cimas et al (2016), I argue that within-country differences [in decentralized states] in the realization of the human right to health are just as fundamental to take into account as differences between countries. Understanding these differences is vital for human rights advocates aiming to further the realization of human rights. Overall, in relation to the realization of the human right to health, it can be confirmed that regional governments have contributed to bottom-up pressure to adopt human rights standards at the national level and take human rights obligations more seriously. The latter, therefore, is an argument in favor of the 'democratization of human rights instruments', a proposition that calls for future research.

Discussion

Within the academic debate about the implementation of human rights, the regional level has too often been overlooked (especially in non-federal countries). Scholarly attention has primarily focused on the nation state on the one hand, and more recently cities, among which human rights cities, on the other. My research addresses this gap within existing literature and introduces two relevant concepts within the academic debate about the implementation of human rights; the human right polity and the democratization of human rights instruments. Moreover, it explores the underlying reasons why regional governments are more successful in human rights implementation. This thesis has attempted to shed light on the gaps that exist within countries in terms of the realization of human rights through a case analysis of the human right to health in the context of irregular migration. The approach adopted here, namely analysing political opportunity structures, contentious governance and the formation of collective actors, may provide insights for other researchers that are interested in understanding gaps in human rights implementation. The findings may be especially interesting for researchers interested in (federal) states where competencies, and thus the ultimate responsibility of human rights realization, is decentralised.

This work is practically concerned and addresses ways in which human rights can be realized through the formation of collective actors, contentious performances and political opportunity structures in a context where a state implemented legislation that denies the human right to health [for irregular migrants]. Therefore, besides academics, my research may provide insights for human rights advocacy officers and/or lobbyists, given that my research stresses the importance of taking into account within-country differences in human rights implementation and explores the ways in which one can make sense of these differences by looking at both structural factors, performances and mobilization. In other words, this specific understanding of human rights implementation may provide insights for strategies to further the realization of human rights.

Certain limitations of my research should be acknowledged. My (verbal) fluency in Spanish is modest, which has influenced the way I conducted my research. Especially in relation to the interviews, it was challenging to intervene in Spanish, but this has been partly resolved by making use of a translator. Nevertheless, it should also be acknowledged that the use of a translator accompanies its own limitations, such as problems surrounding interpretation (Temple, & Young, 2004). Overall, given that the main analysis has been written documents (and that I can read Spanish relatively well), I believe language limitations, although influential, have not significantly affected my results; it primarily posed an extra (interesting) challenge for me, which affected me time-wise, more than anything else.

Another limitation has been the limited number of interviewees, and the bias that may exist among them. Despite many emails and phone calls, gaining access to informants in the regional health ministries proved to be a challenge due to un-answered e-mails and/or the bureaucratic and time-consuming way to arrange an interview (e.g. in the case of La Rioja). The limited access to regional health ministries was partly resolved by slightly changing the focus of my analysis towards legislative and administrative documents. Having interviewed informants in Cantabria and Navarra, it must be noted that at the moment the interviews were conducted, progressive, centre-left wing parties ruled these regions (in contrast to before 2015). In other words, they are the progressive autonomous communities that have designed universal healthcare systems and therefore are not representative of PP regions. Especially in Cantabria, where the health director was interviewed [which is a more political figure], as opposed to the legal advisor in Navarra, this may have tainted the kind of answers given. For future research, more interviews should be conducted, especially also in regions ruled by right-wing parties, to reduce any bias. Although this may have affected my research, the main analysis has been the 34 legislative documents; which is why I believe interviewing right wing governments will in all likelihood lead to complementary findings, not necessarily contradicting ones.

Moreover, among other things, there have been certain methodological implications of looking at legislative and administrative documents that may have influenced my research. Although the documents at hand contain contentious claims, they did not fully encompass the relational aspect of contentious performances and the formation of collective actors. Moreover, inherently, legal claims may differ from political ones, and written claims may differ from verbal ones voiced in regional parliaments, or in the news. Future research could look into these other areas to explore more in depth the relational aspect of contentious governance and the formation of collective actors.

Lastly, in light of limitations, it must be noted that, given the scope of my thesis, socio-historical and political-cultural factors and differences among the regions (which move beyond path dependency) have not been sufficiently taken into account. Given the overall importance of these factors in politics, I suggest these could be more adequately taken into account in future research, building and complementing on the theoretical and practical findings of this thesis, with the aim of trying to understand the uneven implementation of human rights.

Now that limitations have been discussed, the solution proposed to democratize human rights instruments in relation to the emergence of new nationalism should be shortly, but critically, discussed in relation to proposing future research ideas. As has been touched upon before, accommodating within-country differentiation into human rights instruments by democratizing them would allow lower levels of government, among which human rights polities, to participate in human rights instruments and mechanisms and co-sign treaties. Democratizing human rights treaties and instruments would create political opportunity structures that could facilitate human rights protection on the ground. However, disadvantages also exist, such as human rights fragmentation. In line with other research that focuses on human rights cities (Oomen, & Baumgärtel, 2014), my research affirms that regional governments are generally more inclusive [in the context of health] than the national government. Therefore, executed well, the democratization of human rights could provide complementary protection, not substitute state protection. Although my research has proven that even without the democratization of human rights instruments, human rights fragmentation within countries is already a reality, the effect of human rights fragmentation and the democratization of human rights instruments should be critically researched.

The latter is especially important given its potential and the recent international developments that can be observed. The world is changing. Traditional polities are being challenged and new polities are emerging. These developments ask us to rethink and adapt our human rights instruments to the volatility of everyday global and local politics. Why merely let countries take responsibility for human rights when many tasks are devolved to lower levels of governments who actually carry the ultimate responsibilities to ensure human rights protection? Given the emergence of human rights cities and human rights polities, and in line with the findings of my thesis, democratizing human rights instruments may further strengthen bottom up pressure to take human rights obligations more seriously, in addition to curbing chauvinistic nationalism, which only recently was referred to by the United Nations Human Rights Chief Zeid Ra'ad Al at the opening of #HRC38 as *'the most destructive force to imperil the world [...]'* ("Opening statement," 2018).

Naturally, one may disagree with this more normative position, which one could write a separate thesis on, but in any case, regardless of political feasibility, I believe it to be relevant to look into the possibilities and research and analyze the advantages and disadvantages of the democratization of human rights in relation to human rights polities, something which could be taken up by those already interested in the development of human rights cities and the localization of human rights.

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Annex 1. Overview of Analyzed Legislative & Administrative Documents

| Autonomous Community | Law/norm + Date | Description |
|-------------------------|--|---|
| Andalucía | Instruction of 6/6/2013 | The recognition of the right to healthcare in centres of the Public Service of Andalusia to foreigners in an irregular situation and without resources |
| Aragon | Instruction of 30/04/2013 | The creation of the Aragonian program of social protection of public health. |
| | Instruction of 9/04/2014 | Healthcare and treatment of special cases for public health reasons |
| | Instruction of 7/8/2015 | Regulating the access to health care in Aragon for foreigners without sufficient financial resources or health care coverage in the national health system |
| Asturias | Instruction of 18/6/2012 | The authorization of healthcare, on a provisional basis, to foreigners in an irregular situation without resources. |
| | Instruction of 30/08/2012 | The authorization of healthcare, on a provisional basis, to foreigners in an irregular situation without resources. |
| Balearic Islands | Announcement of 30/08/2012 | General criteria of application on the health assistance to all people who do not have the condition of insured or beneficiary. |
| | Instruction of 17/07/2015 | The procedures to be carried out in order to guarantee the right for foreigners without sufficient financial resources to access healthcare |
| Canary Islands | Order of 14 /12/2012 | Actions in the field of health promotion, prevention of disease and provision of health care addressed to unauthorized foreigners that are not registered as residents of the Spanish territory, and who lack resources sufficient economic |
| | Order of 16/08/2013 | Modification of the norm of |

| | | |
|---------------------------|---|--|
| | | December 14, 2012 |
| | Order of 14/12/2015 | Modification of the actions in relation to health promotion, disease prevention and the provision of healthcare for foreigners without resources |
| Cantabria | Order SAN/20/2013 | The creation of the Cantabrian Program of Social Protection of Public Health and the procedure to access it |
| | Order SAN/38/2015 | Regulating the inclusion in the Public Health System of Cantabria of people residing in the Autonomous Community who do not have access to a public health protection system |
| Castilla La Mancha | Order of 9/02/2016 | Universal access to health care in the Autonomous Community of Castilla-La Mancha. |
| Castilla y León | N/A | N/A |
| Catalonia | Instruction of 10/2012 | Access to public health to foreign citizens registered in Catalonia who do not have the status of insured or beneficiaries in the National Health System |
| | Instruction of 08/2015 | Access to public health to foreign citizens registered in Catalonia who do not have the status of insured or beneficiaries in the National Health System |
| | Ley 27/06/2017 (Ley 9/2017) | The universalization of healthcare from public funds through the Catalan Health Service |
| Euskadi | Law of 26/06/2012 (Decreto 114/2012) | The system of health benefits of the National Health System in the Autonomous Community of Euskadi |
| | Instruction of 25/1/2018 | Comprehensive health protection program for the prevention of disease, health promotion, and health care for people in an irregular administrative situation who are registered in a municipality of Euskadi |
| Extremadura | Instruction of 15/07/2013 | The creation and application of the Follow-up Health Care |

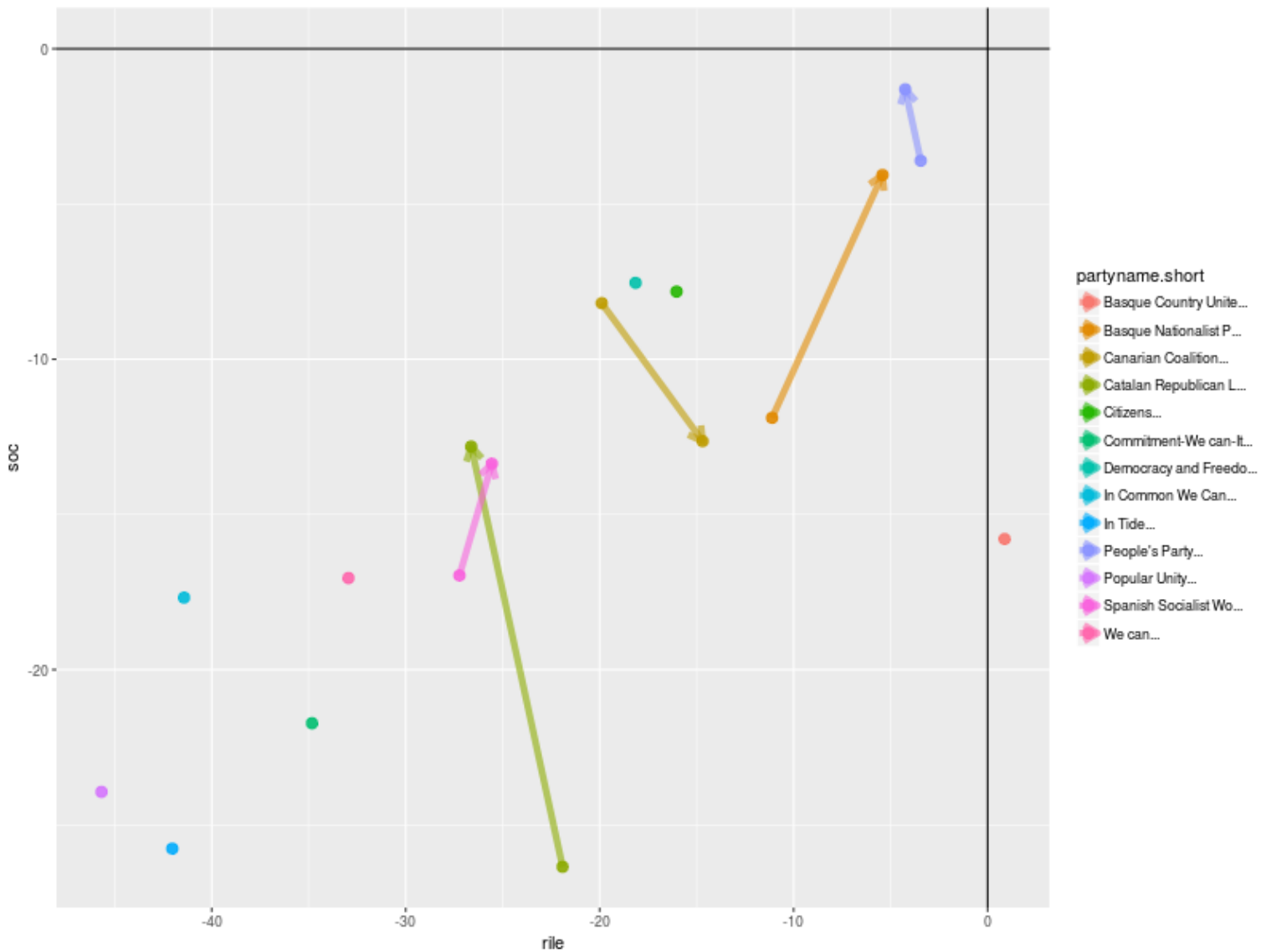
| | | |
|-----------------|---|---|
| | | Program in the Autonomous Community of Extremadura (PASCAEX). |
| | Law of 21/7/2016 (Ley 7/2016) | Extraordinary measures against social exclusion. |
| Galicia | Resolution of 31/08/2012 | The provision of healthcare in Galicia to people who do not have the status of insured or beneficiary recognized by the National Institute of Social Security or by the Social Institute of the Navy |
| | Resolution of 21/09/2012 | The creation of the Galician Program for Social Protection of Public Health |
| La Rioja | Announcement of 02/09/2015 | Health Ministry proposes to maintain the same procedure for assisting illegal immigrants in all communities |
| | Announcement of 8/10/2015 | The management of health care for immigrants in an irregular situation |
| Madrid | Instructions of 27/08/2012 | Instructions on health care to be provided by the Madrid health service to all those who do not have the status of insured or beneficiary |
| | Announcement of 21/08/2015 | An email informing health professionals that healthcare must be provided to people in an irregular situation in the Community of Madrid |
| | Interior Notice of 28/08/2015 | Health assistance to people in irregular situation. Note of clarification |
| Murcia | Instruction of 31/07/2014 (No. 4/2014) | The provision of health care in the SMS centres to foreigners who are in the special situations included in article 3 of Law 16/2003, of May 28, of Cohesion and Quality of the National Health System. |
| | Instruction of 17/11/2015 | Creation of a social protection program for the prevention, promotion and provision of health of the foreign population in irregular administrative situation, resident in the Region of Murcia and with insufficient |

| | | |
|-----------------|---|--|
| | | resources. |
| | Instruction of 22/02/2016 | Modification of social protection program for the prevention, promotion and health care of the foreign population in irregular administrative situation, resident in the Region of Murcia and with insufficient resources. |
| Navarra | Law of 25/02/2013 Ley Foral 8/2013 | Recognition of the right of free access to healthcare for people living in Navarra |
| Valencia | Instruction of 31/07/2013 | The implementation of the Valencian Health Protection Program |
| | Law of 24/07/2015 (Decreto-ley 3/2015) | Regulations on universal access to health care in the Valencian Community |

Source: own elaboration (based on [Yo Sí, Sanidad Universal](#) and Cimas et al. (2016)).

Annex 2: Overview of Political Party Positions

Relative party positions in the 2015 Elections Compared to the 2011 Elections



Note: On the y-axis one can derive the conservative – progressive position of the parties. On the x-axis one can derive the relative right-left positions of the party (based on rile index). According to this plot, none of the parties is a truly 'right-wing' party, as it derives party positions from issues discussed in the party programs and neglects to include more verbal aspects and performances, which is why I relate to the right-left positions in a relative way (relative to one another). Source: Manifesto Project. See Volkens et al. (2017)

Annex 3: Information Sheet on Healthcare for Irregular Migrants in Cantabria



Los centros sanitarios de Cantabria prestan atención a todas las personas nacionales o extranjeras, "incluidas las no registradas ni autorizadas a residir en España" (Orden SAN/38/2015, de 7 de agosto).

Si necesita asistencia sanitaria, pregunte al personal de recepción del centro de salud o llame a estos teléfonos de información:



Health centers in Cantabria attend to all persons, both natives and foreigners, inclusive of those neither registered nor authorized to reside in Spain (Regulation No. SAN/38/2015, of 7th August)

If you need health care, ask at the reception desk in your health centre or dial the following telephone numbers and ask for information:



Les Centres Sanitaires de Cantabria offrent des soins médicaux à toute personne espagnole ou étrangère, même a ceux qui ne sont ni enregistrés ni autorisés à résider en Espagne (Ordonnance SAN / 38/2015, le 7 Août).

Si vous avez besoin de soins médicaux, demandez au personnel d'accueil de votre Centre de Santé ou téléphonez aux numéros ci-dessous:



تقدم المراكز الصحية في كانتابريا خدماتها للجميع، سواء المواطنين أو الأجانب، "بما في ذلك غير المسجلين وغير الحاصلين على إذن الإقامة في إسبانيا" (القانون رقم س ان / 38/2015، تاريخ 7 أغسطس)

إذا كنت بحاجة إلى الرعاية الصحية، اسأل موظفي مكتب الاستقبال في المركز الصحي، أو اتصل على الأرقام التالية للاستفسار والحصول على المعلومات:



Bërëp bou fadjoukay you Cantabria yi gnëp lagnou fi nékal, boromi réw mi ak gan yi fi dëkoul yeup tamit, ba gni ngua khamné amougrou carte d'identité national bou Espagne (ordre San/38/2015, du 7 Aout).

Bo sokhla doctor yi séét la, lathie tél thi gni nék thi récéption you bërëp bou fadjoukay yi wala ngua woté thi numéro téléphone yi..... nguir gnou khamale la.

Teléfonos del SCS para información:

942 202770

942 207772



Annex 4. Interview Guide

The Regional Ministry of Health of Cantabria/Navarra (questions were asked in Spanish)

1. Could you describe to me who you are and what you do for the health ministry?
>> How long have you been working for the health ministry?
2. In general, how would you describe the health ministry and its role in relation to the development and execution of health policies and services in the autonomous community?
3. How would you describe RDL 16/2012?
4. In what way did RDL 16/2012 change the healthcare system in the autonomous community and how did the regional health ministry respond to RDL 16/2012?
5. Can you explain to me why *Orden SAN/20/2013* (Cantabria) / *Ley Foral 8/2013* (Navarra) was enacted?
6. Back in 2012, your autonomous community was ruled by the same/a similar political party that enacted RDL 16/2012 at a national level. Could you describe to me why the Partido Popular in Cantabria/the UPN in Navarra has been more sympathetic toward providing access to health services for irregular migrants compared to the national party?
7. In what way has the decentralisation of the health system facilitated the creation of more inclusive policies in the autonomous community?
8. In deliberating on how to respond to RDL 16/2012, to what extent has the health ministry in your autonomous community cooperated with other health ministries or regional governments?
9. Could you describe to me the response by the central authorities following the more inclusive legislation in your autonomous community? Have the central authorities in any way repressed your efforts in designing inclusive policies following RDL 16/2012? If so, in what way?
10. What do you think has been the role of street level bureaucracy in providing healthcare to irregular migrants, e.g. doctors refusing not to treat someone because of their Hippocratic Oath?
11. Could you describe to me how irregular migrants are informed about their rights in terms of healthcare?
12. Can you describe to me how civil society organisations responded to RDL 16/2012 in your autonomous community?
13. Civil society actors have criticised the drafting process of RDL 16/2012 as they argue that the process did not involve any consultations with relevant stakeholders. To what extent do you share this critique?
14. Are there any estimates on how many irregular migrants have been excluded due to RDL 16/2012 and/or included due to your autonomous community's response to RDL 16/2012?
15. In designing more inclusive regional policies in response to RDL 16/2012, which kind of arguments (e.g. social, economic etc.) and or type of language do you use to legitimize your policies?

Medicos del Mundo

1. Could you describe to me who you are and what you do for Medicos del Mundo?
2. How would you describe RDL 16/2012?
3. What has been the role of Medicos del Mundo in challenging RDL 16/2012? To what extent would you say it has been a priority for the NGO?
4. Could you tell me a bit more about REDER?
 - >> Why and how was REDER set up?
 - >> What does REDER do?
 - >> What is your role in the network?
5. What has been the importance of the network in creating more inclusive policies at the regional (or national) level? Has there been any success as a result of the platform/network?
6. What are the strategies you deploy to advocate against RDL 16/2012?
7. Have the central authorities in any way repressed your efforts to fight against RDL 16/2012? If so, how?
8. To what extent do you think the decentralization of the health system facilitated the fight against RDL 16/2012?
9. Why do you think that some autonomous communities with a ruling centre-right party designed inclusive health policies, while others did not?
10. What do you think has been the role of street level bureaucracy in providing healthcare to irregular migrants, e.g. doctors who refuse to treat someone because of their Hippocratic oath?
11. Could you describe to me how you lobby at national and/or regional level?
 - >> To what extent is the decentralized health system taken into account when advocating against RDL 16/2012?
12. To what extent do the most inclusive autonomous communities adhere to the universality of the human right to health?
 - >> What is the strategy of Medicos del Mundo or REDER in relation to the autonomous communities that have designed inclusive health policies vs. those that have not?
13. How did the movement against RDL 16/2012 spread over Spain?
 - >> Are there certain regions where the social movement is stronger than others?
14. When advocating against RDL 16/2012, what arguments and / or type of language do you deploy in the struggle for moral authority?
 - >> What has been the relevance of human rights?